A Phenomenological Investigation of Pre-qualifying Nursing, Midwifery and Social Work Students' Perceptions of Learning from Patients and Clients in Practice Settings

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Dedication

I would like to dedicate this thesis to my parents who gave me the confidence to start my PhD and the perseverance to complete it.

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Abstract

Government policies have emphasised the importance of patient and client involvement in all aspects of health and social care delivery, with a corresponding impetus for their involvement in the education of practitioners. Professional education programmes adopt andragogical, student-centred approaches and incorporate both academic and practice based learning and assessments. Practice experience is recognised as a crucial aspect of student learning and has become a major focus of quality reviews in health and social care education. Whilst it might seem self-evident that students on practice placements will learn from their interactions with patients and clients, this is a relatively neglected area for formal modeling, evaluation and research. This study, therefore, explores pre-qualifying nursing, midwifery and social work students' experiences of learning from patients and clients during practice placements.

The research project is underpinned by a descriptive phenomenological approach and the extensive data are analysed using phenomenological reduction (Giorgi, 1989a; 1989b). Two key themes and six categories emerged from the data. The first theme is presented as the 'Ways of Learning' and this comprises the categories of: facilitation of learning; critical incidents/patient stories; and role modeling. The second theme is presented as the 'Nature of Learning' and comprises three categories: professional ideals; professional relationships; and understanding patients' and clients' perspectives.

It is evident that contemporary theories, including andragogy, social learning, experiential, reflective and transformative learning theories, remain relevant to professional education. The new knowledge obtained in this research is that the

most powerful learning opportunities result from unplanned, informal learning opportunities involving interactions with patients and clients. However, this is not fully explained by these contemporary learning theories. This thesis will, therefore, argue that complexity theory is relevant to the requirements of professional education programmes. It will present an overarching framework to explain the data from this study and will propose strategies to harness the complexity inherent in this important aspect of student learning.

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Introduction to Thesis

This thesis is situated within the context of professional education in health and social care. It arose from the researcher's interest in professional education, specifically practice based learning, which is a central aspect of her role. The extensive literature related to professional education highlights major tensions between the need for practitioners to be fit for practice at the point of qualification, maintaining the interests of public safety, whilst adopting the ethos of higher education to empower students throughout their studies. The specific focus of this enquiry - learning from patients and clients in practice settings - arose from the findings of the researcher's Master's Degree dissertation which identified that this was a valuable, but largely often unrecognised aspect of practice learning. This thesis will describe pre-qualifying nursing, midwifery and social work students' experiences of learning from patients and clients in practice settings. It will report on the nature of that learning, as expressed by students, and on the ways in which they learned.

The following research aim was formulated to guide the thesis:

- To explore pre-qualifying, nursing, midwifery and social work students' perceptions of learning from patients and clients in their practice placements.

It was anticipated that the research enquiry would address the following broad questions:

- What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements?

- What teaching and learning strategies are used to promote learning from patients and clients in practice settings?
- How relevant are contemporary learning theories to the phenomenon of learning from patients and clients in practice settings?
- How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

Definitions of patients and clients have changed over recent years from the traditional perspective that this referred only to people who are current or past users of the service, with direct experience to impart, to contemporary, more inclusive definitions to include potential users who are eligible to access services and anticipate future need or choose not to access available services (Swift, 2002). It is important to note that patients and clients reject definitions that imply that they are passive recipients of services, but rather emphasise their active engagement with these services. They argue that they should be treated as people first and foremost (Turner in "Shaping Our Lives National User Network", 1998; 2002). Although a range of terms are used in the literature (patients, clients, carers and service users) the terms 'patients' and 'clients' will be used in the thesis, referring to health and social care respectively. However, throughout this thesis, the researcher will emphasise the active role of these individuals, in both health and social care services and in professional education. It is also important to clarify that in the context of this study, students are learning from their interactions with patients and clients as part of everyday experiences. This is a different approach from that which is evident in much of the literature; that is, learning from patients and clients who adopt the roles of teachers, in classroom settings.

The researcher's own philosophy in relation to both health and social care and to professional education has been influenced by the seminal works of Paulo Freire (1994; 1996; 2005) and Ivan Illich (1971; 1977; 1995), which she first read many years ago and has revisited several times during the development of this thesis. Illich is widely quoted in professional literature in respect of his criticisms of the medicalisation of life and professional dominance, arguing that "professionals assert secret knowledge about human nature, knowledge which only they have the right to dispense" (Illich, 1977, p.19).

Both Freire and Illich argue for an empowerment approach to education and Freire's work in particular has been very influential in challenging the role of educators:

> The role of the educator is not to "fill" the educatee with "knowledge", technical or otherwise. It is rather to attempt to move towards a new way of thinking in both educator and educatee, through the dialogical relationships between both. The flow is in both directions (Freire, 2005, p.112).

Towards the latter part of the development of the thesis, the researcher attended a conference presentation by Professor Ronald Barnett and subsequently became familiar with his recently published philosophy of education (2007). This philosophy emphasises the ontological as well as the epistemological perspectives of education and their importance in a student's will and motivation to learn. The researcher was also introduced to complexity theory by a colleague who has published widely in this area (for example, Cooper, Braye and Geyer, 2004; Cooper and Geyer, 2007; Cooper and Geyer, 2008). She subsequently read extensively around this, attended seminars and discussed the theory with colleagues and supervisors in relation to the context of this thesis. This led to the researcher testing and confirming her own philosophical stance in

relation to the empowerment of individuals in health and social care and to student empowerment in higher education. However, it is important to note that the researcher is cognisant of the requirement for public protection and the need, therefore, for the inclusion and assessment of competencies within professional programmes. The researcher was aware of her own knowledge and experience at the start of the study and used a reflective journal and discussions with supervisors throughout the PhD process, to minimise the effect of these.

The researcher's own conceptual framework, relating to the facilitation of learning in practice settings, altered during the development of the thesis. Her original stance was that all learning should be actively facilitated by mentors, practice teachers and lecturers. However, consideration of Barnett's (2007) notion of pedagogical space and complexity theory's concept of the zone of complexity led to the belief that rather than trying to control all learning, the role of the educator is to develop an enabling infrastructure to create the conditions for learning.

The researcher's educational philosophy is consistent with the philosophy underpinning descriptive phenomenology, in which the researcher presents the findings in the voices of the respondents without interpretation. Giorgi (2006) argues that the participant is the expert in relation to the phenomenon under investigation: "the researcher may know theories and the literature, but he or she does not know the relevant dimensions of the concrete experience being reported by a participant" (p.10).

This is directly relevant to the context of this thesis; the researcher has extensive experience of leading professional education programmes and extended her theoretical knowledge, during this research study, by critically reviewing relevant literature. This

quote is consistent with the researcher's philosophical stance that students' knowledge and experience should be valued in the education process.

An overview of the content and development of the thesis now follows:

Chapter 1: Professional Education in Health and Social Care: Policy Drivers and Theoretical Basis.

This thesis is situated within the context of professional education in health and social care. The first chapter of this thesis reviews the large number of government publications over the previous ten years, which have impacted on health and social care services and consequently the education of health and social care professionals. The complexities of professional education are discussed, with consideration of: inter-professional learning; potential conflicts between university and practice based experience; and the inherent tensions in programmes which aim to empower students and also to achieve specified competencies. Chapter one evaluates the relevance of contemporary theories of learning to the context of this research, with a specific focus on andragogy, experiential, reflection, transformative and social learning theories. The emerging theory of complexity is also considered and is further explored throughout the thesis as an alternative theoretical perspective for professional education.

Chapter 2: Learning in Practice Settings: a Critical Review of Policies and Literature

Recent professional publications have stressed the value of learning in practice settings to ensure that students are fit for practice at the point of qualification and it is a regulatory requirement that students access suitable placements during their

programmes. Chapter Two critically reviews the body of literature in relation to learning in practice within pre-qualifying nursing, midwifery and social work programmes, which lead to professional registration. This includes practice learning approaches and environments, facilitation of learning in practice settings, and the roles of lecturers, mentors and practice teachers. The extensive literature reviewed confirms the importance of practice learning and the vital role of mentors and practice teachers in promoting that learning. Although the majority of research comprises small scale studies, these provide evidence of the complexity of practice experiences and of the importance of relationships in the learning process.

Chapter 3: Learning from Patients and Clients – a Critical Review of the Literature

Government policies emphasise patient and client involvement in all aspects of health and social care delivery, with a corresponding impetus for involvement in professional education programmes. The literature reviewed in chapter three demonstrates a lack of empirical evidence to support the involvement of patients and clients in nursing, midwifery and social work education. The majority of literature accessed refers to learning from patients and clients in classroom settings, with relatively few publications directly relating to learning from patients and clients in practice. The literature demonstrates widespread support for the involvement of patients and clients in professional education programmes, whilst raising several issues which need to be addressed. Eight main themes are extrapolated from the literature: partnerships with patients and clients; surveys of current practice; programme planning; teaching; structured dialogue; assessment; stakeholder perceptions; and consumer academic roles.

Chapter 4: Philosophical and Methodological Considerations

Chapter four commences with clarification of the research aim and questions, in the light of the literature reviewed in the previous chapters; it then outlines the philosophical and conceptual approaches to the research. The choice of research approach is justified, in respect of the range of paradigms and research approaches considered, in terms of their relevance to the focus of the enquiry. The decision making process is articulated, with reference to the ontological, epistemological and methodological stances of these paradigms and their congruence with those of this thesis. The chapter concludes that the philosophy of descriptive phenomenology, proposed by Husserl (1859-1938), is appropriate to explore the phenomenon of learning from patients and clients in practice settings, both as an underpinning philosophy and as a research approach.

Chapter 5: Design and Methods

This chapter discusses Giorgi's descriptive phenomenological research method (1989b; 2000c) and describes how this is applied in practice. It presents the design and methods used in this study including: the pilot study; access, consent and ethical considerations; the recruitment and sampling strategy; data collection; and the data analysis process. The research design includes unstructured, conversational interviews, which elicited a large amount of rich data relating to learning from patients and clients. The data analysis process described by Giorgi (1989b; 2000c) is applied rigorously to the data to ensure the quality of the study. Issues relating to methodological rigour are also addressed in relation to the criteria of credibility, fittingness, auditability and confirmability (Sandelowski, 1993).

Chapter 6: Ways of Learning

This chapter provides a comprehensive discussion of the data relating to the first theme of ‘Ways of Learning’, with consideration of the existing body of knowledge, in relation to learning in practice settings. This theme includes the three categories of: motivation; facilitation of learning; and patient stories/critical incidents. The data provide evidence that all respondents are motivated to learn, that they recognise their responsibilities for their own learning, and that they demonstrate considerable commitment to both the programme of study and to their chosen professions. Respondents describe their learning from patient stories and critical incidents, in terms of recognising both effective and ineffective professional relationships. It is evident that mentors and practice teachers have a major impact on respondents’ experiences of learning but that this is in terms of support rather than active facilitation of learning. The findings indicate that experiential learning theories and theories of reflection are directly relevant to respondents’ experiences of learning from patients and clients in practice settings. However, they do not appear to be sufficient, on their own, to explain the learning which is described.

Chapter 7: Nature of Learning

This chapter presents a comprehensive discussion of the data relating to the second theme of ‘Nature of Learning’, with consideration of the existing body of knowledge, in relation to professional education. This theme includes: professional ideals; professional relationships; and understanding patients’ and clients’ perspectives. The main findings in relation to this theme relate to the tacit knowledge associated with professional values and relationships, rather than knowledge and skills. The data indicate that respondents recognise the potential power imbalance which is inherent in professional relationships. They also clearly demonstrate their recognition of the importance of understanding the

situation from the patients'/clients' perspectives. Many of the respondents challenged systems of care and the attitudes of other professionals and then advocated for the patient or client to overcome these. Respondents are also able to articulate their own development in terms of their ability to act as advocates, through the programme, as their knowledge and confidence increased.

Chapter 8: Conclusion and Theoretical Framework

The final chapter of the thesis synthesises the previous seven chapters to present a theoretical framework to explain the phenomenon of learning from patients and clients in practice settings. This incorporates the contemporary theories of andragogical, experiential, reflective, social learning and transformative learning theories, and the evolving theory of complexity. The implications for Higher Education Institutions are considered and strategies are suggested to harness, rather than attempt to eliminate, the complexities of learning in this context.

Chapter 1: Professional Education in Health and Social Care: Policy Drivers and Theoretical Basis.

1. Introduction to Chapter

This thesis will be developed within the context of health and social care and their corresponding education programmes. Professional education programmes adopt an andragogical, student-centred approach and incorporate both academic and practice based learning and assessment. Tensions can be identified within professional education programmes, in relation to several competing agendas: professional competence and student empowerment; professional roles and inter-professional learning; organisational cultures in education and practice settings; the integration of theory and practice and the relationships between patients, clients and professionals.

This chapter will commence with a critical evaluation of relevant health and social care policies. Reforms to health and social care have been a major aspect of this government's policy since it came into power in 1997 (Cabinet Office, 1997) and published the White Paper 'The New NHS: Modern, Dependable.' (Department of Health (D. H.),1997). This White Paper set out the government's ten-year plan to modernise services and to replace the internal market of the previous government with integrated care based on patient need. In total, forty seven relevant policies were reviewed, which all demonstrate the commitment to reforming public services. The main themes identified in these policies are extrapolated and their implications for professional education programmes are discussed. The main themes, in the context of this thesis, are:

- Public involvement in health and social care has led to corresponding involvement in education programmes.
- Target driven approach to care has led to a competence driven approach to education.
- Integrated services have led to the requirement for interprofessional and interagency working and the promotion of interprofessional learning in education programmes.
- Increased focus on community services, voluntary and independent sector organisations have diversified students' placement experiences – this will be discussed in the following chapter in relation to learning in practice settings.

A central theme of the government reforms is public involvement in all aspects of service design and delivery; there are corresponding professional requirements to involve patients and clients in nursing, midwifery and social work education. This is particularly relevant to the context of this study and will be further explored in Chapter Three which critically reviews the literature relating to learning from patients and clients. Recent reforms to the NHS and Social Services have implemented a target driven approach to care; this has led to a competence based approach to education programmes. This will be considered in detail in this chapter, in which the tensions inherent in professional programmes are discussed.

Government and professional policies promote integrated services and inter-agency working; this requires health and social work education to incorporate inter-professional learning opportunities. Interprofessional learning is now a major focus of many professional programmes but often adds to the tensions already present in relation to the competing demands on students. These will be explored later in this chapter. The

modernisation of health and social care has led to an increased focus on community services, with recognition of the contributions of voluntary and independent sector organisations. This has implications for the placement circuit accessed by students and will be further explored in chapter two which critically reviews the literature relating to learning in practice settings.

This chapter will also evaluate a range of learning theories which currently underpin professional programmes in relation to the above policy drivers. The student centred approaches are most relevant to the context of this thesis and, therefore, this chapter will provide an overview of traditional theories and then focus on student centred theories. It will also consider the relevance of complexity theory, which has recently been proposed as an alternative to contemporary approaches to health and social care services and education. It is apparent that there are tensions inherent in professional education programmes, which are increasingly outcome focused, but which also need to develop practitioners who have the necessary cognitive skills to be effective in the rapidly changing context of health and social care.

2. Government and Professional Policies

This chapter will continue with a critical review of the extensive policies published by the current government, over the past decade, to promote health and social care reform. These policies were developed in the context of widespread dissatisfaction with health and social care, to provide greater transparency and promote a more active notion of citizenship (Appleby and Rosete, 2003; Coulter, 2003; Health Service Ombudsman for England, 2003; Newman, 2001).

2.1 Patient and Client Involvement

Participation of citizens in the design and delivery of all public services has been a key theme within the labour government's approach to public sector reform (Cabinet Office, 1997; Chief Medical Officer, 2001; Department of Health (D.H.), 1997; 1999a; 2000a; 2000b; 2001a; 2001b; 2003a; 2003b; 2003c; 2004a; 2004b). For example, one of the main threads of the numerous recommendations of the Kennedy enquiry into paediatric deaths at Bristol Royal Infirmary (D.H.,2000b) was that patients and carers must be fully involved in and 'at the heart of' the NHS. The subsequent NHS plan (D.H., 2000a) emphasised the need for patients to have more say in their treatment and more influence on the delivery of services: "for the first time, patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works" (p.12).

The government highlighted the threats to public trust in the NHS, particularly in relation to failures in communication and accountability and produced a policy to promote patient and public involvement at all levels (D.H., 2003b). It has also engaged in a range of listening and consultation exercises to explore public views and has increasingly used patient satisfaction surveys to influence care (Opinion Leader Research, 2006). This emphasises the highly political nature of the public services within the context of an ever-increasing gap between public expectations and actual provision (O'Neill, 2005).

These reforms included a major programme of modernisation within personal social services, with a change of emphasis from local authority provision to individual budgets for service users (D.H.,1998; 2005; Her Majesty's Government, 1996; 2003). They also include a target driven approach to quality; further emphasis on primary care; the

integration of services; inter-agency working and the introduction of local commissioning and social enterprise (Department for Education and Skills (DfES), 2003a; D.H, 1999a; 2000a; 2001c; 2004c; 2006a; 2007a; Her Majesty's Government, 1990; 1996; 2001a; 2002; 2003). The principles of person-centredness, autonomy and promoting independence are central to this modernisation programme. The expertise of patients and clients is widely recognised (Beresford, Shamash, Forrest and Turner, 2005; Hasler, 2003). '*The Expert Patients Programme'* (Chief Medical Officer, 2001) provides an example of government recognition of this knowledge in relation to individuals with long term conditions. The programme facilitates individuals to increase their own knowledge and confidence, in order to manage their own conditions.

However, Scourfield (2007) and Turning Point (2004) caution that this emphasis on independence and choice raises concerns as to the status of individuals who remain dependent on others. This is reinforced by responses to reforms in social care which aim to empower individuals, for example with the introduction of the direct payment system (D.H., 2003d; 2005; Her Majesty's Government, 1996; 2003). The implementation of these reforms may, in fact, result in a deficit model assuming that social care will provide support mechanisms rather than enabling strategies (National Institute of Adult Continuing Education, 2005), may not advantage all patients and clients equally (Commission for Social Care Inspection, 2004; Leece and Leece, 2006), and may result in tokenistic involvement (SCOPE, 2005). Indeed, SCOPE (2005) contends that current models of working with disabled people are limited, even tokenistic, with only a small group of individuals involved and under representation of black and ethnic minority groups, people with learning difficulties and those with mental health problems. It argues that "the expertise of service users is possibly the most under utilised resource in social care" (SCOPE, 2005, p.11).

The rhetoric of government and professional policy in relation to patient and client involvement in health and social care may not be evident in the reality of practice . Indeed, Bradshaw (2003) argues that many of the changes are 'cosmetic' and that service users have few mechanisms to change care. Curriculum development and delivery must involve patients and clients, and be responsive to the constantly changing needs of organisations. Ager, Dow and Gee (2005) advise that professionals who are responsible for these education programmes must address the mandate to involve patients and clients. Pre-qualifying education programmes for the health and social care professions emphasise the value and importance of learning in practice and curricula have recently been strengthened to emphasise this. Stakeholder involvement in the pre-qualifying programme is specified in '*The Requirements for Social Work Training'* (D.H., 2002) and includes employers, universities, students, clients, practice assessors, external examiners and the General Social Care Council (GSCC). Stakeholders have roles in student selection, curriculum design, teaching and learning provision, preparation for practice learning, provision of placements, learning agreements, assessment of students and quality assurance processes. The specific issue of client involvement was given increased priority with the introduction of the new social work degree programme (D.H., 2002). This recognises that they are experts in their own care and aims to ensure that newly qualified social workers treat clients as active participants in service delivery, not as passive recipients. For the first time education providers were required to include clients as stakeholders in all aspects of programme development and delivery. Elliott et al. (2005) advocate a real and meaningful collaboration with patients and clients. However, they report from consultation with stakeholders that professional and regulatory requirements could result in tokenistic participation.

2.2. Targets and Competence within Professional Education

The NHS plan sets out strategies and national targets to address clinical priorities, for example by reducing waiting times for treatment, improving health and reducing inequality (D.H., 2000a). To support the implementation of these reforms, the government has published a number of National Service Frameworks (NSFs) (D.H., 2007b). These are long term strategies, involving a range of services and organisations, to improve specific areas of care which set measurable goals within set time frames. Currently there are NSFs for the areas of coronary heart disease (D.H., 2000c); cancer (D.H., 2000d); mental health (D.H., 1999b); older people (D.H., 2001d), diabetes (D.H., 2001e); renal services (D.H., 2004e); children, young people and maternity services (Department for Education and Skills (DfES) and D.H., 2004; D.H., 2004d), with others currently being developed. The influential report '*Changing Childbirth*' (D.H., 1993), published by the previous government, reviewed maternity services to provide women-centred care. It is claimed that this has had a positive impact on care, although its impact has been adversely affected by under resourcing of the initiatives (Cumberledge, 2003). There have also been criticisms of the effectiveness of the current target driven approach to maternity care (National Childbirth Trust, 2007; Royal College of Midwives and Royal College of Physiotherapy, 2006). In addition, Newman (2001) cautions that New Labour's extensive use of performance indicators is a regulatory and controlling system of quality management which may conflict with the espoused values of individual choice and independence.

This target driven approach to health and social care is reflected in the major policy drivers in higher education for widening and increased participation and the integration

of education and business needs. This has led to an increased focus on skills based and vocational programmes with an emphasis on programme outcomes and employability. The White Paper 'The Future of Higher Education' and accompanying paper 'Widening Participation in Higher Education' (DfES, 2003b; 2003c) outline the government's long term strategies for investment and reform in order to reduce the social gap in university entrants and expand higher education provision to provide the skills needed by employers. The papers demonstrate commitment to increase funding of students from lower income families; increase participation in higher education; promote the exchange of knowledge and skills; and to develop both the research and teaching agendas. Widening participation remains one of the main priorities for the current government and is a major focus for the Higher Education Funding Council for England (HEFCE 2006). This is reflected in professional education which, whist adhering to professional entry requirements, actively promotes diversity of students and flexible approaches to programme delivery.

These policies are also reflected within educational programmes leading to initial qualification as a nurse, midwife or social worker, which aim to prepare students for a rapidly changing work environment. Although this requires the development of practitioners with high levels of cognitive skills to positively influence care, the reform agenda led to corresponding changes in the aims of professional education programmes which have become increasingly competence based (D.H., 2002; GSCC; 2002a; Her Majesty's Government, 2001b; 2004a; 2004b; Nursing and Midwifery Council (NMC), 2002; 2004a; 2004b; 2004c; QAA, 2000; TOPSS, 2002). However, the tensions within professional education are evident, in terms of the nature of knowledge in theory and practice and the professional regulatory body requirements to achieve prescribed competencies at the point of qualification (Cowan, Norman and Coopamah, 2005).

This competency approach has led to concern that professional programmes may become reductionist in nature and may lose their holistic focus (Kelly and Horder, 2001; Talbot, 2004). However, government and professional publications also recognise the need to prepare autonomous professionals who can act independently in decision making (General Social Care Council (GSCC), 2002a; Mailloux, 2006; NMC 2004a; 2004b). It is evident that professional education occurs in the context of multiple interests, including professional bodies, government, employers, patients and clients (Dick, Headrick and Scott, 2002). This means that students undertaking programmes are subject to a number of competing agendas including prescribed curricula content, developing skills for learning, critical thinking, promoting conceptual understanding and connecting areas of theory and practice (Eraut, 1994; 2000; 2004; 2005). Stark and Stronach (2006) highlight the debate between competence and empowerment frameworks in health and social care and the plural influences of practice and education settings. They contend that "…. an interesting contrast emerges between education, which is consciously trying to empower, and a situation in practice, which is disempowering" (p.81).

Professional programmes differ from traditional higher education, in that they are delivered in both higher education institutions and practice settings and their purpose is foremost about practice. In addition, professional education occurs in the context of multiple interests, including professional bodies, government, employers and recently patients and clients (Dick et al., 2002). This means that students undertaking professional education programmes are subject to a number of competing agendas including prescribed curricula content, developing skills for learning, critical thinking,

promoting, conceptual understanding and connecting areas of theory and practice (Eraut, 2005).

Eraut's (1994) influential work on professional learning is widely acknowledged in the literature. His description of professional knowledge contains three main elements: propositional knowledge; personal knowledge; and process knowledge. Propositional knowledge is conceptual, it includes discipline specific theories, principles and assumptions; personal knowledge results from experiences and interactions and process knowledge involves using propositional knowledge skilfully to contribute to professional action. Eraut contends that practice is complex and requires the integrated and purposeful use of several different kinds of knowledge concurrently. He also advises that knowledge is forgotten if it is not used in practice and, therefore, topics should be introduced within a relevant context and at the appropriate time. However, Eraut (2005) cautions that students also have to contend with discontinuity of learning between university and practice settings, because there may not be a discourse of theory in practice contexts and theory is often front loaded in professional programmes.

There has been a long standing debate within professional education as to the relative emphasis on competence and skills acquisition and on cognitive and affective development. The Nursing and Midwifery Council and General Social Care Council requirements for programmes leading to professional qualification are prescriptive and outcome based, focusing largely on the assessment of competence (GSCC, 2002a; NMC, 2004a; 2004b; TOPSS, 2002). This has led to concern that professional programmes may become reductionist in nature and may lose their holistic focus (Kelly and Horder, 2001; Talbot, 2004). However, government and professional publications also advocate autonomous professionals who can act independently in decision making

rather than functioning within a culture of inter-dependency (Mailloux, 2006). Eraut (2005) contends that this leads to competing agendas for students on professional programmes with inevitable tensions between prescribed content and the aims to develop critical thinking skills, conceptual understanding and to connect theory and practice. He further argues that there are no currently agreed definitions of what constitutes 'theory' and 'practice'. In addition, it is suggested that currently there is no agreed holistic definition of competence (Fullerton, Severino, Brogan and Thompson, 2003) to encompass the complex combinations of knowledge, performance, skills and attitudes and its measurement is even more problematic (Cowan, Norman and Coopamah, 2005; Watson, 2002). This is supported by the findings of a small scale qualitative study which reported that a range of attributes, including personal characteristics, were considered in practice, within the concept of competence (Bogo, Regehr, Woodford, Hughes, Power and Regehr, 2006).

The outcomes of professional education curricula leading to qualification as a social worker, nurse or midwife are set by the GSCC and NMC respectively. Both professional regulatory bodies are involved in the initial accreditation, revalidation and quality monitoring of programmes to ensure that students are fit for qualification at the point of award (D.H.,2002; Her Majesty's Government, 2000; 2001b; 2004a; 2004b; NMC, 2002; 2004c; Quality Assurance Agency (QAA), 2000). Curricula have become increasingly outcome focused (National Institute for Mental Health, 2003a; NMC, 2004a; 2004b; TOPSS, 2002) to ensure that they meet all the appropriate standards (D.H.,2006b; Musselwhite and Freshwater, 2006; Sainsbury Centre for Mental Health, 2001; Skills for Health, 2006).

In 2002, the Department of Health reviewed social work education and training (D.H., 2002). The aim was to reflect the needs of service users and carers for a high quality service; to fully prepare professionals for their new roles and tasks; to promote joint working with other professions; to encourage flexible access to social work training and to improve the quality and status of social work education (GSCC, 2002a). Social work education in England moved to degree status in 2003 and includes new areas in relation to service user involvement, the place of research-minded practice, and the primacy of practice. It is anticipated that this will increase the status of social workers, improve recruitment and ensure that students meet professional standards at the point of qualification (Manthorpe, Hussain and Moriarty, 2005). Similarly, nursing and midwifery education is moving towards an all graduate entry to the profession at the point of qualification.

2.3. Integrated Services and Interprofessional Learning

It is evident that there are a range of complexities and tensions inherent within professional education programmes. An additional challenge, for health and social care education, is to prepare professionals for inter-agency working and for roles with increasingly flexible boundaries. Initiatives to promote and develop inter-professional learning followed the introduction of the '*NHS and Community Care Act'* (Her Majesty's Government, 1990) to enhance future inter-professional working relationships. The White Paper '*Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards'* (D.H.,1998) identified problems with existing social service provision, including inflexibility of services, lack of co-ordination between

agencies, lack of consistency and inadequate protection of vulnerable children and adults. Within the National Health Service (NHS) Plan social services and health services were brought together for the first time and the relationship between the NHS and the private sector was strengthened. The Department of Health published a complementary document '*Shifting the Balance of Power Within the NHS: Securing Delivery'* (D.H., 2001a) to provide guidance for employers to break down demarcations between professional groups and to empower front line staff to make decisions locally. However, research into staff involvement in implementing the NHS Plan concludes that although health professionals are central to the reforms in services, they do not feel engaged in them and feel unsupported in the change processes (Royal College of Midwives and Royal College of Physiotherapy, 2006). The report recommends improved communication and increased involvement of health professionals in the reform agenda, commissioning processes and service changes.

Interprofessional working is, therefore, essential to the integration of health and social care, which is one of the central tenets of the government's health and social care reforms (Ahmed, 2007; Care Service Improvement Partnership, 2006; DfES, 2003a; 2007; D.H., 2001a; 2001b; 2004c; 2004d; 2006a; 2006b; D.H., NHS Employers, NHS Trade Unions, 2007). These reforms required changes in the roles and responsibilities of professionals working within health and social care settings (D.H., 2000a) and a new Act of Parliament was approved to facilitate these (Her Majesty's Government, 2002). It is evident that multi-agency working is essential, in order to respond to the policy drivers to integrate service delivery (Dowling, Powell and Glendinning, 2004; Edwards and Miller, 2003; Glasby, Dickinson and Peck, 2006). These policies mean that inter-

professional and inter-agency working need to be an important focus of learning in both university and practice based experience.

It is argued that shared learning between different professional groups is essential to prepare social work and health professionals (Bezzia, Keogh and Keogh, 1998; Cook, Davis and Vanclay, 2001; Karban, 2003). Lumague et al. (2006) reported that students recognised the importance of interprofessional teamwork and agreed that education programmes should enable them to develop these skills. Carpenter, Schneider, Brandon and Woof (2003) evaluated an interdisciplinary ethics course and concluded that it enhanced students' abilities to engage in interdisciplinary aspects of practice. Cooper, Spencer-Dawe and McClean (2005) also evaluated the outcomes of an interprofessional education approach and concluded that this prepared students effectively for placement experiences and also increased their confidence in their own professional identity. Freeth, Reeves, Goreham, Parker, Haynes and Pearson (2001) report the findings of an innovative project to develop an interprofessional learning environment in a hospital ward, using reflection and problem based learning approaches. The project was positively evaluated by students and facilitators, but Freeth et al. (2001) stressed the vital role of facilitators and the importance of their preparation for this role. An extensive evaluation of an inter-professional learning curriculum reported that students' responses were more positive about inter-professional learning in practice settings than in university. The experience of inter-professional learning in practice settings was largely via informal, rather than formal, mechanisms and was influenced by inter-professional relationships and communication networks. Students also reported that mentors had a crucial role in promoting this learning (Pollard et al., 2007). The evaluative studies discussed above indicate positive outcomes

associated with interprofessional learning, but it is important to note that the majority of the research included is evaluative in nature and many studies focus on specific programmes which have an interprofessional focus. No studies were identified which addressed the transference of interprofessional learning during education programmes to interprofessional or interagency working in practice.

Health and social work professionals increasingly find themselves working in multi-disciplinary settings and interacting with a wide range of health, local authority, voluntary and independent organisations. This change in service delivery has led to increased opportunities for learning for students in multi-disciplinary settings. However, it is evident from the literature review, that there are a range of issues which still need to be addressed in respect of interprofessional working. For example, professional knowledge deficits (Christianson and Roberts, 2005), poor communication, conflicting power relationships, and role confusion (Rolls, Davis and Coupland, 2002). Glasby (2003) suggests that, despite its prevalence in government policy, barriers remain within health and social care which inhibit this, and goes so far as to refer to these as the 'Berlin Wall'. These barriers include structural divisions, separate legal and financial frameworks, differences in governance and accountability and distinct professional and organisational identities. Dowling (2006) contends that the evidence to date has focused on the process of inter-professional working rather than the outcomes for patients and clients. She reported the findings of a case study of socially deprived children and concluded that the differences in training and ideology of different professionals affected their values and the theoretical perspectives which they applied to practice. In an empirical study of general practitioners, social workers and community nurses, Hudson (2002) identified differences between the professional groups in respect of professional identity, professional status and professional discretion and accountability. Richardson and

Asthana (2006) argue that these differences adversely affect the exchange of information between professional groups and they report that there are conflicting pressures to share personal information across agencies and to protect confidentiality.

The discussion above supports the suggestion by Cook, Davis and Vanclay (2001) that interprofessional approaches to practice learning require structural changes to professional programmes to align placement requirements. Worsley (2007) advises that students need to be adequately prepared if they are to benefit from these learning opportunities. He also argues that students need support from enablers, if they are to learn effectively within the ever changing contexts of health and social care environments and the potential tensions between professional groups

The review of the professional, regulatory body requirements for nursing, midwifery and social work education has re-enforced the tensions discussed previously in relation to the competing demands within programmes. It has also highlighted the discrepancy between government policy to integrate health and social care services and the distinct bodies which have been set up to assure the quality of education provision for the professions. Despite the rhetoric to promote inter-professional learning, the quality assurance of health and social care education, in both HEI and practice settings, remains fragmented with separate reviews by the QAA and professional bodies (Skills for Health, 2006; Skills for Health, 2007; TOPSS, 2002).

It is evident from the above review of recent government policy that curriculum development and delivery need to involve patients and clients and to promote inter-professional and inter-agency working. Health and social care professionals need to be

responsive to the constantly changing needs of organisations and service users. This requires the development of practitioners with high levels of cognitive skills to positively influence care. However, the tensions within professional education are evident, in terms of the nature of knowledge in theory and practice and the professional regulatory body requirements to achieve prescribed competencies at the point of qualification. These will be discussed further below.

2.4 Context of Health and Social Care

It is evident from the policies reviewed so far in this chapter that there have been far reaching changes in health and social care over the past decade. These have involved increased public involvement in all aspects of planning, delivery and evaluation of services, a target based approach to quality of services, and the integration of health and social care. In addition, the government reforms have led to major changes in the nature of organisations which are responsible for these services. The White Paper '*Our Health, Our Care, Our Say: a New Direction for Community Services'* (D.H., 2006a) sets a new direction for health and social care as a unified system. The paper reinforces the government policy of moving health services from secondary to primary care and outlines strategies to empower General Practitioners to commission services. Voluntary and independent sector organisations have become increasingly involved in the delivery of health and social care services during the term of this government. One of the most recent aspects of these patient led reforms involves social enterprise organisations, which include co-operatives, trusts and community interest companies (D.H., 2006a; D.H., 2007a).

It is apparent, therefore, that professionals need to be prepared to work in a range of care settings and to adapt to the rapidly changing contexts of health and social care. This has led to major changes in the placement circuits for health and social care students, who now access a diverse range of organisations to complete the practice requirements of their programmes. The major changes in health and social care, and consequently in professional education, led the researcher to consider alternative theoretical frameworks. This led to an in-depth exploration of complexity theory, which is applied below in relation to both health and social care and to professional education.

3. Complexity Theory in the Context of Health and Social Care

Complexity theories have become increasingly popular in health and social care in recent years, in response to growing dissatisfaction with traditional scientific approaches. Santanus (2006) contends that society as a whole is changing and that it requires new paradigms to understand this. He argues that: "Change is ubiquitous, and stability and certainty are non-concepts in complexity theory" (p.1).

This statement has particular resonance to the current context of health and social care discussed above and led the researcher to further explore complexity theory in relation to health and social care and to their corresponding education programmes.

Complexity theory developed from chaos theory, and before that catastrophe theory (Gleick, 1997). Gleick describes how a number of scientists, working in different fields in the 1960s and 1970s, came to similar conclusions in respect of the limitations of traditional scientific theories in the United States. Although chaos and complexity have

similarities, in that both recognise disorder as a natural part of life and both adopt nonlinear approaches, complexity is described as being on the edge of chaos, forming part of a continuum from linear systems to non linear chaos (Bak and Paczuskin, 1995; Kauffman, 1995; Lewin, 1993). Waldrop (1992) contends that simplistic, linear models are not sufficient to explain the ways in which complex adaptive systems respond to the demands of the constantly changing, external environment. He contends that these systems develop and change in order to survive, by means of networks and connections, self-organisation and emergence and the relationship with the external environment. Cilliers (1998) identifies six attributes of complex systems. They are unpredictable; non-linear; sensitive to initial conditions; stress the relations between components of the system rather than its structure; demonstrate emergent properties or behaviour; and incorporate the researcher. It is apparent that complexity is inherent in all systems but that this increases from physical complexity, through the biotic complexity of plants and animals to the most complex systems which involve humans with their norms, values, language and narratives.

Health and social care have traditionally been underpinned by the paradigm of order, which led to a scientific approach which valued cause and effect, led to the growth of large scale hierarchical organisations and increased specialisation and differentiation of services. Within this scientific approach, health is seen as a biomedical process and the doctor was viewed as authoritarian and the patient as a passive recipient of care (Geyer, 2008). Sweeney (2002) contends that the scientific model traditionally used in healthcare is no longer sufficient, on its own, to meet the needs of professionals in relation to the complexity of service delivery. Sweeney argues that there are a number of paradoxes inherent in the scientific model: it is linear whereas healthcare is non-linear; it does not explain emerging conditions whose progression is unpredictable; and it does

not recognise the connectedness of its elements. He contends that the scientific model still dominates despite recent challenges to its appropriateness and argues that although it is value free, the professionals implementing it are not and it does not equip them for difficult situations, for example death and dying. Plsek (2000) argues that mechanical systems allow prediction in great detail, but in complex adaptive systems, the parts can respond in unpredictable ways. He relates this to health care systems, advising that the parts then include the humans within those systems.

Complexity theory challenges simple cause-and-effect models, linear predictability, and reductionist approaches. Rather it focuses on large, open, dynamic systems and environments as a whole and on the connections and relationships between constituent elements, rather than the reductionist approach of traditional scientific theories (Santanus, 2006). This is directly relevant to complex organisations which contain a large number of networks and interacting agents, which are typical attributes of health and social care environment. This seems to be relevant to the above policy drivers in terms of the changes to service delivery and to the need to prepare professionals to work effectively in ever changing health and social care organisations.

There are several recent publications which apply complexity theory to health and social care. Cooper and Geyer (2007), for example, writing in relation to diabetes, contend that new theories are needed to explain the expanding paradigm of human knowledge. They argue that this knowledge is not necessarily related to order, nor does it give greater prediction or control and that it has no universal endpoint. They also advise that the human condition adds a further layer of complexity that is distinctive from the natural world, in terms of language, norms and discourses. Other examples include Sweeney and Griffiths (2002) in respect of primary care; Sweeney (2006) in respect of general

practitioners; Tennison (2006) focuses on epidemiology and public health; Kernick (2004) focuses on healthcare organisation and Sweeney and Cassidy (2006) focus on clinical governance and Fraser and Greenhalgh (2001) suggest that complexity theory is relevant to medical education.

Plsek and Greenhalgh (2001) advise that complexity theory is relevant to health care organisation, practice, education and research. They emphasise the limitations of reductionist approaches to explain the complex nature of health care and advocate the use of complexity theory, because it accepts unpredictability and values both creativity and autonomy. They apply complexity theory to management thinking in healthcare and they conclude that effective organisation and delivery of health care should embrace the creativity and abilities of its staff, rather than focusing on targets and control, which are part of the current systems.

It is evident, from the above discussion, that complexity theory is relevant to the context of health and social care. Following an evaluation of the learning theories which currently underpin professional programmes, the researcher will explore and apply complexity theory to the recent changes discussed above.

4. Learning Theories

Historically, health and social care education programmes were based on a rational scientific approach and were underpinned by behavioural and cognitive theories of learning. With the move of pre-qualifying education programmes into higher education settings, these programmes adopted a more holistic, student centred approach to

learning (Purdy, 1997a; 1997b; Rogers, 1969). However, as discussed earlier in this chapter, there has recently been concern that the target driven approach within health and social care services has led to a return to outcome focused curricula. Indeed, Dalley, Candela and Benzel-Lindley (2008) recently argued that this learner centred approach is currently inhibited by the increasing content within professional programmes and they advocate 'de-crowding the curriculum' (p.62) to address this barrier.

The so called 'theory-practice gap' in professional education has been the focus of a long-standing debate and it has been suggested that the change from the traditional apprenticeship models of training to the development of academic programmes may have contributed to this (Hislop, Inglis, Cope, Stoddart and McIntosh, 1996). Greenwood (1993b) contends that students learn an alternative set of theories during practice placements and suggests that these do not relate to those taught in university. Dale (1994) refers to this as the 'theory-theory gap' as opposed to the 'theory-practice gap', because he believes that experiential knowledge should be valued as the theory underpinning professional practice.

The traditional behavioural and cognitive theories remain relevant to professional education and will be outlined below and will lead to a consideration of social learning theory and its associated learning strategy of role modeling. Humanist, student centred learning theories will then be explored, with a specific focus on reflective practice and problem based learning as the major strategies which currently underpin the programmes in the context of this research.

4.1 Behavioural Learning Theories

Behavioural theories originated in the early part of the twentieth century. They are based on the assumption that human learning could be predicted by the study of animal behaviour and explained in terms of a model based on stimulus-response. Early behavioural theorists included Pavlov, Watson and Thorndike, whose mechanistic approach to learning by conditioning has been widely criticised (Reece and Walker, 2003). The work of neo-behaviourists, including Thorndike, Skinner and Gagne placed greater emphasis on motivation and the reinforcement of learning. These were highly influential in early professional education programmes, which adopted behavioural objectives models (Quinn and Hughes, 2000). The discussion earlier in this chapter highlighted the tensions between the competence requirements of professional bodies and the empowerment approach of higher education. It is apparent that behavioural theories are still relevant to pre-qualifying education programmes, particularly in respect of skills acquisition.

4.2 Social Learning Theory and Role Modeling

Bandura's (1977) social learning theory was originally developed to explain the phenomena of aggression in adults and psychological disorders, behaviour modification approaches and modeling as therapy with recent works focusing on self-efficacy (Bandura, 1997). The theory emphasises the importance of learning from the observation of the behaviours and attitudes of others. It incorporates cognitive and behavioural aspects, recognising the continuous interaction between cognitive, behavioural and environmental influences (Bahn, 2001). The theory is behaviourist in

origin but incorporates cognitive elements in that it encompasses attention, memory and motivation (Quinn, 1994).

It is from this theory that the concept of learning from role models evolved. Bandura (1977) contends that individuals observe and model the behaviours, attitudes and emotional reactions of others and that, following this observational learning and role modeling, they copy both good and bad behaviours. However, he advises that individuals are more likely to adopt modeled behaviour if it results in an outcome they value and if the model is similar to and respected by the observer. The literature supports the contention that students learn from observing both positive and negative role models and that students may adopt inappropriate behaviours modeled in practice. However, this is not supported by the findings of a descriptive longitudinal qualitative study of pre-registration nursing students' socialisation into professional nursing (Mackintosh, 2006). This study reports that some students recognised, but did not model, negative aspects of care. This is consistent with Bandura's (1977) concept of self regulation, in which he argues that individuals control their own behaviour through self-observation, judgment and self-response.

It is widely recognised that expert practitioners act as role models of good practice for students undertaking professional programmes and that modeling is a major learning and teaching strategy used by mentors and practice teachers. Indeed, McLeod, Romanini, Cohn and Higgs (1997) contend that role modeling is "the most powerful teaching strategy available to clinical educators" (p. 54).

4.3 Cognitive Learning Theories

Cognitive theories focus on how individuals gain and structure their knowledge; they propose that students do more than receive information, rather they actively assimilate this into patterns (Reece and Walker, 2003). Dewey (1966) was one of the earliest cognitive theorists and he emphasised the importance of developing pupils' abilities to think. A range of cognitive learning theories have been applied to professional education programmes to influence the structuring of curricula to facilitate the assimilation of knowledge and the development of problem-solving and critical thinking skills (Quinn, 1994). Problem solving, critical thinking and decision making are key outcomes of nursing, midwifery and social work programmes (D.H., 1999c; NMC 2004a; 2004b; TOPSS, 2002) designed to meet the rapidly changing agenda of health and social care. Biggs (2003), for example, argues that self-direction in knowledge is essential for practitioners to be effective in this context. Cooke and Mayle (2002) concur that if learning is active, fun, purposeful and meaningful, deep learning will be undertaken by the student. They propose that active participation in a learning process promotes students to integrate and synthesise knowledge, thus promoting problem solving and critical thinking.

Problem based learning is widely advocated in the literature to promote these cognitive skills and to promote the integration of theory and practice. Problem-based learning is a student centred approach to learning that results from the process of working towards understanding or resolving a problem. The underlying assumption is that students are active learners who construct knowledge in their own individual way. Therefore, by placing learners at the heart of their learning experience, this approach is perceived to

support professional practice (Gidman and Mannix, 2006; Maudsley and Scrivens, 2000; Taylor, 1997). Problem based learning was originally developed within medical education (Barrows and Tamblyn,1980) but is relevant and appropriate for all professionals, because it promotes the development of knowledge, reasoning and study skills and enables students to apply their knowledge and enhance practice (Newman, 2004; Newman, Corner and Tyms, 2004; The Higher Education Academy Social Work and Social Policy Subject Centre (SWAP), 2007a; 2007b; Wilkie and Burns, 2003). It is also recommended as a strategy to bridge the 'theory practice gap' between academic and practice learning (Andrews and Jones, 1996; Barrow, Lyte and Butterworth, 2002; Boud and Feletti, 1997; Burgess, 1992; Creedy, Horsfall and Hand,1992; Dick et al., 2002; Frost, 1996; Margetson, 1997; Murrell, Eaton and Tomsett, 1997a, 1997b; Savin-Baden, 2000; Taylor, 1997).

A review of the literature relating to problem based learning identified that it is a widely used and appropriate teaching and learning strategy within health and social care education programmes The advantages have been described in terms of developing students' cognitive skills, particularly problem solving, decision making and critical thinking and of integrating theory and practice (Carey and Whittaker, 2002; Horne, Woodhead, Morgan, Smithies, Megson and Lyte, 2007; Hwang and Kim, 2006; Rideout et al., 2002; Rowan, McCourt and Beake,2007). These small scale studies largely support the use of problem-based learning as a teaching and learning strategy to promote problem solving, critical thinking and decision making skills. However, all the research focuses on student and/or lecturer perceptions rather than outcomes; this is a major limitation in providing the evidence base to support its widespread implementation.

Some operational difficulties associated with problem based learning are reported in the literature. These include organisational and resource issues (Horne et al., 2007; Ryan, 1997); preparation of lecturers (Barrows and Tamblyn, 1980; Creedy and Hand, 1994; Doring, Bramwell-Vial and Bingham, 1995); level of knowledge gained (Albanese and Mitchell, 1993; Vernon and Blake, 1993) and the transference of knowledge (Andrews and Jones,1996). Although problem based learning was originally used to underpin the entire pre-registration curriculum, due to the issues discussed above it is now used as a learning and teaching strategy within the curriculum, rather than an as approach to deliver the entire programme (Andrews and Jones, 1996; Dick et al., 2002; Frost, 1996; Gidman and Mannix, 2006; Murrell et al., 1997a; 1997b; Taylor, 1997).

4.4 Andragogy

Education programmes which prepare social workers, nurses and midwives promote self-directed learning to equip professionals with the skills to become lifelong learners (D.H., 2001c; NMC, 2004a; 2004b; 2004c). It is now mandatory for nurses, midwives and social workers to engage in continuing professional development, to provide evidence of contemporary and relevant learning, in order to remain on the professional register. To promote the development of lifelong learning, student-centred learning is widely advocated in the literature relating to professional education. Lecturers within professional education should not perpetuate existing knowledge and practices, but rather should prepare practitioners who are able to learn throughout their careers and respond to ever-changing situations (Milligan,1997; 1999). Change is now a fundamental characteristic of health and social care and education programmes. There is, therefore, a need to prepare professionals who will embrace this (Thorne, 2006) and

who will adopt innovative approaches to student assessment (Green-Lister, Dutton and Crisp, 2005).

The need for lifelong learning is supported by the discussion earlier in the chapter, which identified the complexity of practice areas. Barnett (2004) suggests that learning for uncertainty involves learning to live with uncertainty and that this requires self-engagement, reflexivity, active pursuit of difficulties and the desire to learn something new about one's self and the world. This aspect of learning will be explored further throughout the thesis and will be considered in relation to the findings of the research enquiry.

Adult learning theory has contributed extensively to nursing, midwifery and social work education (Dick et al., 2002; Purdy, 1997a; 1997b). Adult learning theory has its origins in the model of andragogy, which was proposed by Knowles (1990) in which he identifies differences between the education of adults and that of children. Knowles proposes that adults need to be self-directed in their learning, that they bring past experience to their learning, value experiential learning, prefer immediacy of application and are problem centred in their approach to learning. This has influenced the sequencing of curricula and has led to the inclusion of appropriate teaching and learning strategies, for example, experiential learning, reflection and problem-based learning. Cree, MacCauley and Loney (1998) studied the transfer of learning and report that for it to be effective, learning must be understood; the learner needs to understand the connections between new and existing knowledge, and there must be opportunity to apply the learning to practice. These findings support Knowles' (1990) contention that adult learners prefer immediacy of application to ensure that learning is relevant. This has implications for

curriculum development, which should ensure that the sequencing of learning facilitates the integration of theory and practice.

As indicated above, the humanist approach to education has major implications for the role of lecturers, mentors and practice teachers. The andragogical approach necessitates lecturers to be student-centred and to promote learning, rather than to deliver subject matter and it has been argued that adult education has not reached its full potential because many lecturers are unfamiliar with the approach (Knowles, 1990). With a shift in the demands of health and social care, educators need to re-evaluate existing teaching and learning strategies (Nelson, Sadler and Surtees, 2005), to ensure that professional education maintains momentum and enables practitioners to meet future as well as current demands.

Student centred learning approaches to teaching and learning require increased time and commitment from lecturers, mentors and practice teachers and they require considerable skill to facilitate students' abilities to become self-directed in their learning (Biggs, 2003; Milligan, 1997; Quinn and Hughes, 2000; Reece and Walker, 2003). Little (1997) reports the findings of an action research project which identified the major factors influencing the effective implementation of problem based learning. These included lecturers having an understanding of, and commitment to, the philosophy of the approach; a realistic acceptance of the role change; the ability to model critical thinking and problem solving skills and an acceptance that students need time to change their expectations of the learning process.

4.5 Transformative Learning Theories

Transformative learning theories have been influential in professional education since the seminal work of Jack Mezirow in the 1970s (Brookfield, 2000; Taylor, 2000). Mezirow developed the term transformative learning to refer to changes of meaning and perspective and has published widely in relation to his theory (Mezirow, 1981; 1990; 1991; 2000). Mezirow (1990) defines learning as: “the process of making a new or revised interpretation of the meaning of an experience, which guides subsequent understanding, appreciation, and action” (p.1). His theory of transformative learning proposes that critical reflection enables individuals to critique their presuppositions and to correct distortions in their beliefs. However, Mezirow’s theory of transformative learning has been criticised because of its focus on conscious reflection as the process of learning (O’Sullivan, 2003). This is interesting, given the priority given to reflection, as a teaching and learning strategy, in professional education.

Nohl (2008) contends that transformative learning can occur following spontaneous action and he suggests that this presents a major challenge for educationalists, in that it is impossible to both initiate and accompany this spontaneous learning. Barnett (2007) goes further. He proposes that genuine higher education should lead to a transformation of being. Indeed, in his recently published philosophy of higher education, he argues that ontology is more important than epistemology in learning. He suggests that students’ being and experience are inextricably linked and that over the period of his/her course the student will change his/her conceptual perspective on life.

These contrasting perspectives of transformative learning will be considered in relation to the data obtained in this research in chapters six and seven and will be incorporated into the theoretical framework developed at the end of the thesis.

4.6 Experiential Learning and Reflection

Experiential and reflective learning are widely advocated, as strategies to promote learning, in professional education to promote learning from practice. Because of the specific relevance to the context of this thesis, these will be explored in greater detail than the theories reviewed above.

The importance and validity of learning from experience is advocated in Patricia Benner's (1984) theory, '*From novice to expert'*, which has been very influential in the education of health and social care professionals and is widely used to promote and assess the development of skills and competence. Benner describes the expert, but often tacit, knowledge demonstrated by experienced nurses and she argues that intuition is an important aspect of the development of professional expertise. Benner describes five stages of development, which she refers to as novice, advanced beginner, competent, proficient and expert. Benner's theory is often applied within a competence framework in professional education programmes, for example to assess continuing professional development.

Lyneham, Parkinson and Denholm (2008) support the validity of intuitive practice. However, they advise that education programmes should not aim to teach expertise, but rather to promote reflection, research and clinical curiosity in their students; this may be

inhibited by the current focus on competence. Fowler (2008) argues that experiential learning has diverse outcomes, from skill acquisition to personal development. He also contends that experiential learning focuses learning on the individual's experience, rather than the outcomes of the programme, and that this is consistent with the consciousness raising approaches of Illich (1971) and Freire (1996), discussed earlier.

Theories underpinning experiential learning identify that learning occurs as a separate process from the experience itself and propose that this learning requires conscious reflection. Kolb's (1984) theory of experiential learning has been described as having a major impact on the move from a reductionist to non-reductionist perspective in education (Kelly, 1997) and his experiential learning cycle has been highly influential in professional education (Cree et al., 1998). Freire (1994), in his influential writings in Latin America, advises that the learner needs to be engaged in an experience if learning is to occur, but warns that experience cannot be accepted as a given, learning requires it to be critically evaluated. Learning from experience requires more than experience alone (Andrews, 1995; Hogan, 1995). Indeed, Miller and Boud (1996) use the term 'using experience in learning' to make it explicit that learning does not automatically, or passively, occur during an experience, rather it requires deliberate action on the part of the learner.

Reflective practice is a prominent teaching and learning strategy within professional education curricula, to promote active learning from experience (Andrews, Gidman and Humphreys, 1998; Burnard, 2006; D'Cruz, Gillingham and Mellendez, 2007; Dempsey, Halton and Murphy, 2001; Dick et al., 2002; Glaze, 2001; Graham, 2000; Graham and Meggary, 2005; Heron, 2005; Hogan, 1995; Scanlon and Chermomas, 1997). Reflection addresses the need for practitioners to learn from practice experience

and to use uncertainty to prompt learning. It also provides a strategy to address the complexity of practice in the rapidly changing health and social care climate and to promote the empowerment of individuals (Gidman, 2006; Gidman and Mannix, 2007). However, Lethbridge (2006) cautions that there is limited substantive evidence to either support or definitively refute the value of reflection.

Reflection, as a learning and teaching strategy, has its origins in the theories of Dewey (1938) and Habermas (1971). Both theorists propose that reflection serves to generate knowledge. Dewey focuses on the process of reflection as a means of making sense of the world and emphasises perplexity as a stimulus for learning (Dewey, 1938; Smith, 1999; Times Literary Supplement, 2002). This theory is supported by Lam, Wong and Leung's (2007) findings from qualitative analysis of social work students' learning logs. The analysis identified that disturbing events, encountered in practice acted as a catalyst to the reflective process. Habermas focuses on the acquisition, development and consideration of knowledge as a means to promote the empowerment of the individual (Taylor and White, 2000). The focus on the process, as opposed to the product, of learning makes reflection advantageous to professional education, because it encourages practitioners to examine how, why and what they are thinking and feeling during an experience, rather than focusing on the outcome alone (Taylor and White, 2000). Barnett (1997) contends that Habermas used reflection as a tool to evaluate society and he argues that higher education requires a state of critical being and not just critical thinking, and that emancipatory reflection enables the empowerment of practitioners to understand their true situations and create the freedoms that they need. This is of great relevance to health and social care practitioners who, as discussed above, work within ever changing political and professional contexts.

There is currently no commonly accepted definition of reflection (Carroll, Curtis, Higgins, Nicholl, Redmond and Timmins, 2002). D'Cruz et al. (2007) recently conducted an extensive critical review of literature to distinguish between a range of terms, which are often used inter-changeably, to describe the concept of reflection. They categorise reflexivity as the highest order cognitive skill, involving self-actualisation and reflection in action, with a universal focus which promotes empowerment for individuals as citizens. Critical reflection is categorised as a lower order cognitive skill which promotes critical awareness of self, reflection on action and emancipation for clients.

The work of Donald Schon (1987; 1991), who describes reflection in terms of action, has been influential in the widespread adoption of reflective learning in professional education programmes. Reflection on action is a fairly narrow concept, it is retrospective and may be either verbalised or non-verbalised. In contrast to reflection *on* action, reflection *in* action is situated within the activity itself and is said to occur when there is no obvious action and is associated with theories in use. Schon argues that reflection *in* action only occurs when there are potential unexpected consequences to an action; this is consistent with Dewey's notion of perplexity. Again, it is apparent that this is of great relevance to the education of health and social care professionals; students need to develop the ability to respond to a range of complex situations.

Bennett and Kingham (1993) contend that experiences need to be recorded in order to facilitate effective reflection. Documentation of reflective learning is usually by means of a reflective journal (Hogan, 1995; Dick et al., 2002; Johns, 2005; Shepherd, 2006); portfolios (Jasper, 1995) or by critical incident analysis (Love, 1996; Parker, Webb and

DeSouza, 1995; Francis, 2004; Fook, Ryan and Hawkins, 2000). Al Sheri (1996) reported the findings of a PhD thesis which explored reflective learning, using personal professional journals, with a sample of General Practitioners. Qualitative data indicated that respondents found the process beneficial and, more significantly, quantitative data demonstrated benefits in terms of patient outcomes and satisfaction. Francis (2004) argues that critical incidents have particular value in challenging existing discourses and exploring the complexities of practice experience. However, Martin and Mitchell (2001) analysed critical incidents completed by post-registration nursing students and concluded that, despite the potential advantages of the approach in terms of student learning, there was no demonstrable effect in terms of practice development.

Hindsight bias is an issue raised by several authors (Jones, 1996; Wallace, 1996) who contend that the perception and recall of experience after the event may be inaccurate. Taylor (2006a) also cautions that memory, time, previous experience and individual biography all have an impact on the individual's perception of the experience. The issue of hindsight bias indicates the need for students to reflect on experiences as soon as possible, and fully, in order to prompt accurate recall (Johns, 2005). This implies that mentors and practice teachers, who facilitate students' learning in practice, need to provide opportunities for this learning to occur and to be confident in the use of reflective learning strategies. Students in the previous study by the author (Gidman, 2001a; 2001b) described learning following critical incidents with patients. However, there was little evidence that mentors or lecturers facilitated reflection on these experiences.

Stories have been advocated as strategies to both empower patients and clients and to facilitate learning. Birth stories, for example, are recognised in midwifery education as a valuable tool to help women to understand their experiences of childbirth, and more

recently to promote learning for students (Farley and Widmann, 2001). In his influential work on 'the wounded story teller', Frank (1997) proposes that story telling can help the patient move from a passive to an active role in his/her illness. He contends that illness greatly affects the person's: "….sense of where she is in life and where she may be going. Stories are a way of redrawing maps and finding new destinations" (p.53).

Patient stories are said to be valuable, but often unrecognised, tools to tap into students' imaginations, form meaningful connections, promote learning and enhance reflection (Greenhalgh, 1999; Greenhalgh and Collard, 2003). Although there are a range of different meanings in the education context, it is argued that stories can be "a vehicle to facilitate learning rather than to impart knowledge" (Moon and Fowler, 2008, p.232).

Hallenbeck (2003) and Frank (1997) suggest that professionals and patients have different types of stories, with medical stories valuing objective and rational perspectives, and patients and their families valuing subjective and emotional perspectives. This is relevant to the review of government policy earlier in this chapter which emphasised the active involvement of patients and clients in care and recognised their expertise in professional education.

Lecturers, mentors and practice teachers need to be aware of the power imbalance between themselves and their students; this is particularly evident when the lecturer, mentor or practice teacher is responsible for formal assessment of the student (Brown, 1993). The imperative to achieve academically may discourage reflection that is open and honest and the value of formal assessment is questioned (Hargreaves, 2004). The previous discussion about the tensions between competence and student empowerment

is particularly pertinent to the facilitation of reflection on experience. The assessment of the outcomes, rather than emphasis on the process, of reflection may reinforce the dominant professional discourse rather than encouraging new meanings, interpretations and political positioning which are necessary for professionals to influence practice, rather than conform to existing norms (Cotton, 2001). It is important that lecturers, mentors and practice teachers are skilled in the facilitation of reflective sessions with students (Duke and Appleton, 2000; McGrath and Higgins, 2006; Williams and Walker, 2003) and that students understand the process (O'Donovan, 2006). Indeed, Yip (2006) warns of potential dangers if reflection is not effectively facilitated and supported, suggesting that individuals may suffer stress and anxiety. Burnard (1995) explored nurse lecturers' views about reflective practice in a qualitative research study and reported that, although they valued reflection, respondents were unable to identify specific teaching and learning strategies which they used to facilitate this. Mallick (1998) adds to this debate, arguing that lecturers need to be reflective practitioners themselves if they are to be effective facilitators of reflective learning in their students. Koh (2002) reported that findings of a small scale study, using focus groups, indicated that students perceived that lecturers had a vital role in facilitating them to develop reflective skills in practice. However, students also reported that visits from lecturers were not as frequent as they would have liked.

Although the literature suggests that the concept of reflective learning enhances student learning, there is a lack of research evidence to support this and the majority of studies are small sample, qualitative and context specific. Indeed, Wong, Kember, Chung and Yan (1995) suggest that there is a lack of reliable methodology with which to assess whether reflection is actually taking place. Research studies which have used Meizrow's (1981; 1991) levels of reflection to analyse students' reflective journals concluded that

reflection was evident at the lower levels only (Jensen and Joy, 2005; Richardson and Maltby, 1995). It is apparent, from the above review of the literature, that reflection is a very influential learning and teaching approach within professional education. Reflection is a requirement of professional regulatory bodies and is incorporated into undergraduate, pre-qualifying nursing, midwifery and social work programmes (NMC, 2004a, 2004b; GSCC, 2002a). It is also a specific outcome within programmes to prepare nurse lecturers and mentors (NMC, 2006) and practice teachers (GSCC, 2002b). The above review supports Lethbridge's (2006) stance that, whilst reflection has many perceived benefits, there is currently insufficient empirical evidence to either support or definitively refute its effectiveness.

It is evident from the above discussion that contemporary theories remain relevant to professional education. However, as stated earlier, the researcher also explored complexity theory in relation to professional education and, as outlined in the following discussion, concluded that this is both relevant and appropriate to the context of this thesis.

5. Application of Complexity Theory to Professional Education

As discussed earlier in this chapter, complexity theory has recently been advocated as an alternative to traditional scientific approaches to health and social care (Sweeney, 2002). A range of recent publications propose that complexity theory is also relevant to education theory and philosophy (Doll, 2008; Mason, 2008a; 2008b; 2008c; Semetsky, 2008; Sumara, Luce-Kapler and Iftody, 2008) and to educational research (Santanus, 2006; Davis, 2008; Radford, 2008). Morrison (2008) suggests that complexity theory is

attractive to education because of its critique of positivism, its affinity to Dewey and Habermas and its focus on openness, diversity, creativity, agents and relationships.

The main concepts of complexity theory, as identified from the literature, are illustrated in Diagram 1 below. These will be applied to professional education programmes, with particular consideration of:

- Complex adaptive systems: uncertainty and unpredictability; non-linear; diversity
- Networks: connectedness; relationships; communication; feedback
- Holism and personal knowledge
- Simultaneity
- Distributed control: teaching roles

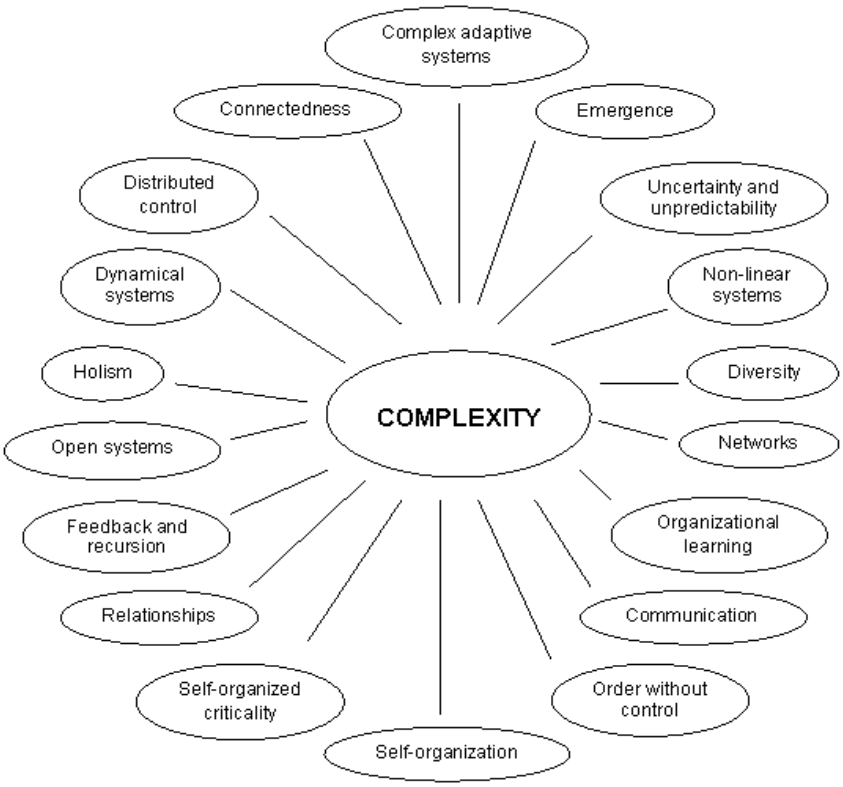

Diagram 1: Concepts of Complexity Theory (adapted from Santanus, 2006).

5.1 Complex Adaptive Systems: Uncertainty and Unpredictability, Non-linear, Diversity

The previous section highlighted the relevance of complexity theory to the health and social care organisations in which students complete the practice elements of their programmes. It was apparent that these are consistent with the concept of complex adaptive systems and that effective practice in health and social care require new ways of working and learning. Mason (2008b) proposes that complexity theory recognises the interactions among the constituent elements in a system. He argues that the addition of new elements or agents to a system multiplies exponentially the number of potential connections and interactions within that system. This has implications for professional education programmes, in which students complete the practice aspects of their programmes in a range of health and social care settings, which are constantly changing in terms of the agents within them. As previously discussed, systems which include human agents have additional complexity in terms of norms, values, language and narratives and the effects of these were evident in the data. The agents in practice settings include staff, patients, clients, carers and students and these potential networks need to be fully acknowledged when considering student learning in this context.

Fraser and Greenhalgh (2001) suggest that traditional medical education and training focuses on competence (knowledge, skills and attitudes) but that the current context of care requires more than this. They argue that complexity theory is relevant to contemporary policy for education in the NHS to develop capability as well as competence (the ability to adapt to change, generate new knowledge and to continuously improve performance). They contend that the use of non-linear teaching and learning strategies, the challenge of unfamiliar contexts and feedback promote this,

suggesting that learning occurs in the zone of complexity, where relationships between items of knowledge are not predictable or linear but neither are they frankly chaotic. The closer one moves towards the edge of chaos, the more creative, open-ended, imaginative, diverse and rich are the behaviours, ideas and practices of individuals and organisations, and the greater is the connectivity, networking and information sharing (content and rate of flow) between participants (Santanus, 2006; Stacey, Griffin and Shaw, 2000). Doll (2008) applies Kauffman's (1995) view of order to education, he argues that direct instruction would be dull, but too much richness may lead to a chaotic frame. Doll (2008) suggests that the development of communication networks and interconnections within curricula can provide stability and flexibility; that is, complexity not chaos. This concept will be explored later in the thesis, in relation to the data and to the development of a theoretical framework to explain learning from patients and clients in practice settings.

5.2 Networks: Connectedness, Relationships, Communication and Feedback.

Feedback occurs between the elements of the system as they interact and this may be both negative and positive. Santanus (2006) contends that negative feedback brings diminishing returns, whereas positive feedback brings increasing returns. The concept of feedback is consistent with social learning theory and role modeling, which were discussed earlier in this chapter and were considered to be particularly appropriate to learning in practice settings.

Effective communication and collaborative learning are essential to promote learning through feedback from the dispersed knowledge in the system. Connectedness is a key

feature of complexity theory, if one element within a system is disturbed then the system must adapt to survive, therefore connectedness through communication is vital. This communication relies on distributed knowledge and control, involving all agents, rather than central control of knowledge and power. This is relevant to the context of this study and will be explored further, later in the thesis, in relation to the theoretical framework.

This chapter has identified that government reforms to health and social care have led to the integration of services, with interprofessional and interagency working and a corresponding requirement for interprofessional learning. Cooper, Braye and Geyer (2004) suggest that complexity theory can provide a framework to scaffold inter-professional education. Complexity theory's recognition of networks, relationship and communication are directly relevant to learning from other professionals and from patients and clients. It may also provide an alternative theory to frame the relationship between patients, clients and professionals (Cooper and Geyer, 2007), as advocated in recent policies.

5.3 Holism and Personal Knowledge

Sweeney and Kernick (2002) criticise the current reductionist paradigm in medicine, arguing that it does not incorporate human values and there are a number of recent publications which advocate complexity theory as appropriate to medical education. However, no publications were identified which considered complexity theory specifically in relation to nursing, midwifery or social work education.

Sweeney (2006) applies complexity theory to knowledge acquisition in general practice. He explains that the history of medicine is characterised by the two fundamental characteristics of science; that is, linearity and reductionism, and that it has traditionally relied on rationalist positivist ontology. He contends that currently, in medicine, statistical and clinical significance are used to assess the value of knowledge and he argues for the recognition of a third level of significance; that is, personal significance: "At stake in the definition of that third level – personal significance – is the centrality of subjectivity and interaction, and of emergence in the clinical encounter. We are forced to consider that this represents a different 'way of knowing' " (Sweeney, 2006, p.44). Griffiths (2002) advises that complexity theory provides a framework to understand and value the knowledge gained from a specific patient, in a specific context. This is relevant to the concept of patient stories which was discussed earlier in this chapter and which will be explored further later in the thesis.

Another of the central features of the government modernisation process is the emphasis on public involvement in all aspects of health and social care. This has major implications for service delivery, which should be patient focused and for the roles of professionals, whose traditional expert power may be threatened. The holistic approach offered by complexity theory, with its recognition of relationships and interconnected networks, is also in keeping with the policy changes in respect of professional and patients' roles in health and social care.

5.4. Simultaneity

Davis (2008) argues for simultaneity; that is, the recognition that events or phenomena are operating at the same time, rather than the current Western position of considering discontinuities which are understood as separate entities. One of the most relevant of these discontinuities, in respect of this study, is that between knower and knowledge, which have been considered as discontinuous in Western thought. Davis proposes that complexity theory may help educationalists to consider these in a more coherent way and to bridge the distinction between curriculum (lecturers' responsibilities in respect of established knowledge) and pedagogy (lecturers' responsibilities in respect of students learning). Davis (2008) proposed that: "For complexivists, *knowledge producing systems* (knowers) and *systems of knowledge produced* (knowledge) are simultaneous, but none collapsible" (p.52).

This stance is supported by that of Osberg, Biesta and Cilliers (2008), who contend that the purpose of Western schools is organised around representational epistemology and that the object of knowledge is considered to be separate from the knowledge itself. Osberg et al (2008) contend that the curriculum should focus on students' engagement with the curriculum as well as the content of that curriculum. Osberg et al. propose that knowledge and reality are part of the same emerging complex system and advocate an epistemology of emergence. This is also consistent with Barnett's (2007) focus on the ontological, as well as the epistemological basis of education and with the experiences of respondents in this study. They clearly articulated their own engagement with patients and with their programmes, in addition to the knowledge which emerged from their experiences.

The difficulties facing educationalists in attempting to provide the optimum environment to promote transformative learning are clearly articulated by Doll (2008) in relation to the nature of the curriculum: “Order emerges from interactions having just the ‘right amount’ of tension or difference or imbalance among the elements interacting. Such a ‘right amount’ cannot be specified; it can only be felt or intuited” (p.202).

The concept of simultaneity is relevant to previous discussion of transformative learning, in relation to professional education, which will be further developed throughout the thesis.

5. 5 Distributed Control and Professional Roles

Doll (2008) discusses complexity theory in relation to curricula, which he suggests has traditionally been influenced by protestant, bourgeois and commercial/capitalist cultures. In these traditional curricula, control and power flows from top to bottom (general to specific) and he argues that this approach constricts thinking, particularly creative thinking. This is in direct contrast to the empowerment approach discussed earlier in this chapter which adopts student centred and transformative learning.

Complexity theory supports the creation of pedagogical space which Barnett (2007) argues in essential for learning. It proposes that the closer an individual moves towards the edge of chaos, the more diverse, creative and imaginative the behaviours and ideas and the greater is the connectivity and information sharing between individuals (Santanus, 2006). Morrison (2008) warns that with its focus on creativity and diversity:

> Complexity theory redefines 'the basics' of education, away from a controlled and controlling discipline-based education and towards a discovered, inter-disciplinary, emergent curriculum, and a reassertion of the *sine qua non* of education. Complexity theory takes us in a direction opposite to the neatly stated, over-determined, tidy, traditional, externally mandated and regulated prescriptions of governments for the aims, content, pedagogy and assessment of learning and education (p.24).

This focus on distributed control is consistent with the andragogical, student centred learning approaches discussed above which are advocated to promote both personal and professional development. The following chapter will evaluate the literature relating to learning in practice settings, including the practice environment and the roles of mentors, practice teachers and lecturers, who are currently responsible for this aspect of student learning.

6. Conclusion to Chapter

This chapter has presented a review of the government and professional policies which are currently driving health and social care and their implications for education programmes leading to professional qualification. The government agenda to reform health and social services has included a quality assurance approach which is based on targets and standards. This has led to corresponding changes in the aims of professional education programmes which have become increasingly competence based. The review of professional education programmes leading to qualification as

social workers, midwives or nurses, highlighted the numerous and diverse outcomes which are required. It is evident that there are potential tensions between outcome driven curricula, which have to conform to rigid professional standards, and the need for professionals to respond effectively to the constantly changing environments of health and social care. These reforms also require the blurring of the boundaries between professionals employed in health and social care, which compound the conflicts already inherent with professional education programmes. One of the central features of the government modernisation process is the emphasis on public involvement in all aspects of health and social care, and consequently in all aspects of curriculum design and delivery. The changes in professional education policy and regulations have also led to increased emphasis on the practice elements of professional programmes, with students accessing a diverse range of placement experiences, within rapidly changing health and social care environments.

Contemporary government and professional policies promote integrated services and inter-agency working; this requires health and social work education to incorporate inter-professional learning opportunities. These reforms have also led to a target driven approach to care and a corresponding competence focus within professional education programmes. Nursing, midwifery and social work programmes adopt andragogical, student-centred approaches and incorporate both academic and practice based learning and assessment. Recent professional and quality assurance requirements have strengthened the emphasis on practice based learning and assessment within these programmes. This has led to tensions within programmes in respect of the competing agendas of professional competence and student empowerment; professional roles and inter-professional learning; organisational cultures in education and practice settings and the integration of theory and practice.

It is evident from the above discussion that contemporary theories of learning remain relevant to professional education. In the specific context of this research - that is learning from patients and clients in practice settings - andragogical, social learning, experiential, reflective and transformational learning theories were particularly applicable (Bandura, 1977; Benner, 1984; Knowles, 1990; Mezirow, 1990; Schon, 1991). This chapter also explored complexity theory and its application to health and social care organisations and to educational theories and philosophies. It demonstrated that health and social care organisations may be considered as complex adaptive systems, in that they are unpredictable, non-linear, demonstrate emergent properties and rely on the relationships between their components. Complexity may, therefore, provide an appropriate framework for the current policy drivers for health and social care and it may provide an alternative perspective for professional education (Fraser and Greenhalgh, 2001; Sweeney, 2002). It recognises the value, and indeed the necessity, of order and control for some aspects of care, whilst acknowledging and valuing the presence of uncertainty (Cooper and Geyer, 2007; Plsek and Greenhalgh, 2001). This will, therefore, be explored further throughout this thesis, in relation to the literature reviewed, the choice of research methodologies, the data and the discussion chapters. This culminates in the inclusion of complexity theory into a theoretical framework to explain learning from patients and clients in practice settings and in the proposal of a range of strategies to harness the complexity of the learning process. Table 1 below demonstrates the development of complexity theory, in relation to learning from patients and clients in practice settings, throughout this thesis.

The extensive government and professional policies reviewed in this chapter have provided evidence of the increased emphasis on the practice elements of professional

programmes with a diverse range of placement experiences (Skills for Care, 2007; Skills for Health, 2006). The researcher concluded that health and social care organisations may be considered as complex adaptive systems. A range of contemporary learning theories was reviewed and it was concluded that andragogical, social learning, experiential, reflective and transformational learning theories are applicable to the context of this study. However, following the review of the literature in this chapter, the researcher also wished to explore the relevance of complexity theory, as a complimentary perspective for professional education. The conclusions of this chapter, therefore, led to the formulation of the following two research questions:

- How relevant are contemporary learning theories to the phenomenon of learning from patients and clients in practice settings?
- How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

Table 1: Table to Demonstrate the Development of Complexity Theory Throughout the Thesis.

Conclusions of Literature Reviews	Complexity Theory Concepts	Methodology	Complexity Theory Concepts	Data and Discussion	Complexity Theory Concepts
Professional education • outcomes vs empowerment	Values order and disorder	Context of study • practice placements	Complex adaptive systems	Ways of learning • patient stories	Values alternative forms of knowledge
Professional education • effective practitioners	Promotes capability as well as competence	Context of study • agents	Networks, relationships, connectedness	Ways of learning • facilitation of learning	Networks, relationships, connectedness
Professional education • student centred	Distributed control	Research approach • phenomenology	Holism	Ways of learning • critical incidents	Learning in the zone of complexity
Practice learning • diversity of practice learning environments	Complex adaptive systems	Research aim • to explore students' perceptions of learning from patients and clients in practice placements	Recognises the complexity of learning	Nature of learning • complexity of learning	Recognises the complexity of learning in practice settings
Practice learning • facilitation of learning	Networks, relationships, connectedness	Research aim • to explore students' perceptions of learning from patients and clients in practice placements	Holism	Nature of learning • professional ideals and relationships	Networks, relationships, connectedness
Learning from patients and clients • policy drivers for public involvement	Distributed control Holism	Research aim • to explore students' perceptions of learning from patients and clients in practice placements	Simultaneity of ontological and epistemological aspects of learning	Nature of learning • patient perspectives	Holism
Learning from patients and clients • no formal strategies in practice settings	Values alternative forms of knowledge			Integration of ontological and epistemological aspects of learning	Simultaneity

Chapter 2: Learning in Practice Settings: a Critical Review of Policies and Literature

Introduction to Chapter

The previous chapter identified that the government agenda to reform health and social services has increased the emphasis on community based services, involving a wide range of agencies and introducing a quality assurance approach based on targets and standards. This led to corresponding changes in the aims of professional education programmes which have become increasingly competence based. It is evident that there are potential tensions between outcome driven curricula, which have to conform to rigid professional standards, and the need for professionals to respond effectively to the constantly changing environment of health and social care. The modernisation of health and social care has led to changes in the education of health and social care professionals, which is multi-faceted, due to the increased diversity and complexity of professional and organisational cultures. These reforms also require the blurring of the boundaries between professionals employed in health and social care, with increased inter-professional and inter-agency working and a corresponding focus on inter-professional learning approaches. The other major theme within the modernisation agenda is increased public involvement in all aspects of health and social care, and the requirement to include patients and clients in education programmes.

The changes in professional education policy and regulations led to an increased emphasis on the practice elements of professional programmes, with students accessing a diverse range of placement experiences. There is consensus in the literature that practice experience is a vital aspect of nursing, midwifery and social work programmes.

Recent professional publications have stressed the value of learning in practice settings to ensure that students are fit for practice at the point of qualification (D.H., 2002; NMC 2004a; 2004b) and it is a requirement that students access suitable placements during their programmes. For nursing and midwifery this entails fifty percent of the programme hours spent in audited practice areas with supervision by an appropriately qualified mentor (NMC, 2004a, 2004b). The introduction of the degree programme for social work also involved an increase in the time that students are required to spend in practice placements, but the exact nature of placements and student supervision is less clearly defined (D.H., 2002). Professional regulatory bodies specify mandatory outcomes and competencies, which are assessed in practice, to ensure that practitioners meet the requirements for qualification (GSCC, 2002a; NMC, 2004a; 2004b; TOPSS, 2002). However, it is evident that this learning is complex and requires a planned, co-ordinated approach by lecturers, mentors and practice teachers.

This chapter will critically review the body of literature in relation to learning in practice within pre-qualifying nursing, midwifery and social work programmes which lead to professional registration. The researcher had extensive knowledge of the literature and professional regulations relating to learning in practice in nursing programmes and was eager to further develop her own knowledge of midwifery and social work programmes and literature. This was in keeping with her professional role, as Head of Practice Learning and Development in a Faculty of Health and Social Care, and with the current context of integrated services in health and social care. A review of the literature was therefore undertaken using a range of databases including: CINAHL; SOC Index; Maternity and Infant Care; Education Research Complete; Cochrane; and Google Scholar. Search terms included: mentor; practice teacher; practice supervisor; link teacher; link lecturer; practice learn; practice teach; clinical learn; clinical teach; learning

theories; reflect; experiential; transformative; transformational; andragogy; problem-based learning; and complexity. In addition, government and professional websites were accessed and relevant policies reviewed. These included: the Centre for the Advancement of Inter Professional Education; Department for Education and Skills; Department of Health; General Social Care Council; Health Professions Council; Higher Education Academy; Nursing and Midwifery Council; Skills for Care and Development; Skills for Health; and Training Organisation for Personal Social Services.

The literature review will be presented with reference to the following themes which were identified:

- Practice learning approaches
- The practice learning environment
- Facilitation of learning in practice settings
    - the role of the lecturer in practice learning
    - the role of the mentor in practice learning
    - the role of the practice teacher in practice learning.

The extensive literature reviewed confirms the importance of practice learning and the vital role of mentors (for nursing and midwifery students) and practice teachers (for social work students) in promoting that learning. Although the majority of research comprises small scale studies, these provide evidence of the complexity of practice experience and of the importance of relationships in the learning process. The review of the literature did not identify any empirical research relating specifically to learning from patients and clients in practice settings. As previously discussed, patient and client involvement in health and social care education is becoming increasingly important and

the current gap in the literature supports the aim of this research, which is to explore the role of patients and clients in student learning in practice settings.

2. Practice Learning Approaches

There is a range of approaches and meanings in relation to practice learning. This thesis will consider practice learning in its broadest sense to refer to learning from practice placements during professional education programmes. It is argued that the central feature of the learning process should be the practice event and that the distinction between practice placements, practice teachers, academic lecturers and university based education should be irrelevant (Evans, 1999). This thesis will use the following operational definition, assuming that learning takes place: “before the event as part of the process of planning, during the event as part of the process of adjusting the practice to a changing or unexpected context and after the event, particularly as reflection” (Evans, 1999, p.4). This is a very broad definition and emphasises the integration, rather than the separation, of all aspects of professional education programmes.

Dick et al. (2002) conducted an extensive review of literature in relation to practice learning in social work education. They concluded that traditional pedagogic methods are not appropriate for adult learners, advising that adult learners are self-directed, need active learning models and bring knowledge and experience to their learning. Reflection on action is reported to be an integral part of practice learning and Dick et al (2002) conclude that knowledge needs to be used in practice to be internalised and propose that theories of learning that rely on theory to practice conceptualisation are less

effective than models that support a dialectical relationship and reject the idea of theory-free action. Recent programme developments have seen an increased emphasis on student centred learning. Reflection and problem-based learning strategies are advocated to promote this and students are encouraged to accept responsibility for their own learning. Before commencing practice placements, students should be aware of their responsibilities for learning and for recording and reflecting on practice (Fell and Kuit, 2007). Peer support and mentoring, involving students learning with and from each other, have been identified as effective strategies to promote responsibility and independence, which increases students' self confidence and learning (Lofmark and Wikblad, 2001). As discussed in the previous chapter, theories of andragogy have greatly influenced professional education programmes in recent years (Cartney, 2000; Dick et al.; 2002; Shardlow and Doel, 1996; Taylor, 1997). However, it is important to acknowledge the potential tensions between this student-centred approach and the competency requirements of professional regulatory bodies.

A previous study by the researcher explored students' perceptions of learning in practice settings (Gidman, 2001a; 2001b). The study adopted a descriptive phenomenological approach to data collection and analysis and comprised in-depth interviews with final year student nurses, who reported learning promoted by reflecting on critical incidents within clinical practice. The research findings demonstrated the value of experiential learning, but it was not evident from students' responses, either their levels of reflection, or the strategies used to facilitate the process. Indeed, the data provide little evidence that mentors or lecturers were actively promoting reflection following these critical incidents. The findings indicate that this process is not explicit and that learning from patients often occurs in an '*ad hoc*' rather than a planned manner. The paper concluded that because the pre-registration nursing programme involves both academic and clinical

aspects, this integration is essential and reflective practice needs to be built into the curriculum, and to be facilitated by both mentors and nurse lecturers. This paper also recommended that all professionals involved in nurse education, and indeed, students themselves, need to be aware of the important role that patients and clients play in respect of practice-based learning.

3. The Practice Learning Environment

It was evident from the review of health and social care policy presented in chapter one that government policies have led to major reforms during the past ten years. The government agenda to reform health and social services has increased the emphasis on community based services, involving a wide range of agencies. These reforms also require the blurring of the boundaries between professionals employed in health and social care, with increased inter-professional and inter-agency working. This has major implications on the placement circuits accessed by students; learning now occurs within a wide range of placements, to provide the practice experience required to meet the outcomes of nursing, midwifery and social work undergraduate programmes. It is apparent from the preceding review of health and social care policy that the education programmes leading to professional registration need to prepare students for a rapidly changing work environment. Curricula also need to reflect the move from secondary to primary settings and to acknowledge the vital role of voluntary, independent and social enterprise partners in practice. As discussed in the previous chapter, complexity theory, with its emphasis on complex adaptive systems, is relevant to these health and social care reforms. It may also provide an appropriate framework for learning in practice

settings and for the preparations of practitioners to work effectively in ever changing environments. This will be further explored throughout this thesis, in relation to learning from patients and clients.

Recent changes have increased the diversity of stakeholder involvement and strengthened the need for a partnership approach to student learning (Pearcey and Elliott, 2004; Welsh and Swann, 2002). The use of placement opportunities in the wider social care sector, including residential care, day centres and home care services is now advocated for social work students (Billingham, Moss and Williams, 2001; Billingham and Roberts, 2002; Buchanan and Millar, 1996; Hardwick, 1998; Manthorpe and Stanley, 1997; Skills for Care, 2007; Smith, Moody, Waterhouse and Dell, 1998). Fairclough (2006) reports the findings of a case study and concludes that practice agencies need to become learning organisations in order to provide effective learning opportunities for students. However, the introduction of the social work degree, with its increased emphasis on practice experience, has led to concerns about the quality and quantity of placements (Collins and Turunen, 2006; Furness and Gilligan, 2004). The same issues are raised in relation to the number of placements required to meet the demands of the NHS plan (D.H., 2000a) for increased numbers of nurses and midwives and the subsequent increase in student numbers (Brennan and Hutt, 2001; Conway and McMillan, 2000). However, despite these concerns students, academic lecturers and external assessors have expressed satisfaction with placement learning and collaboration, in annual quality reviews (GSCC, 2004; 2005; QAA, 2007a; 2007b; 2007c).

For social work programmes, it is currently the university's responsibility to establish criteria for placement areas and to monitor the quality of the learning environment

(National Organisation for Practice Teaching, 2007). However, there is a project in progress to develop a national quality framework for practice learning to standardise the quality of practice experience for social work students (Skills for Care, 2007). This framework will include standards and benchmark statements; a national audit tool and guidelines for the preparation of practice assessors. This framework is intended as good practice guidance to be used and adapted locally, which is in direct contrast to the nursing and midwifery '*Standards for Learning and Assessment in Practice'* (NMC, 2006), which became mandatory from September 2007 (NMC, 2007a; 2007b; 2008a).

Lewin (2006) reports on the findings of a large scale, longitudinal study which compared the clinical learning environment in hospital settings over a twenty five year period. The findings indicate an overall improvement in the quality of placement experiences, largely due to more effective supervision and support of students by better trained mentors. However, Lewin (2006) also concludes that hospital environments are intrinsically more complex than academic environments and that the first concern is patient care not student learning. He also reports that, despite overall improvement, for some students there is "a persisting haphazardness in practice instruction and experience" (p.9). Although this study is large scale and rigorous, it focuses entirely on acute, hospital based placement experience. In the light of the previous discussion in relation to the diversity of current placement circuits, this means that whilst interesting, the findings cannot be generalised to placement experience as a whole.

The quality of education provision within HEIs traditionally focused on academic provision and achievement. However, in recent years there has been an increased focus on the quality assurance of practice placements, where these contribute to the learning experience of students (QAA, 2007a; 2007b). Quality reviews have identified

strengths, good practice and weaknesses in programmes throughout England. Strengths include effective partnership working to plan, develop and implement curricula; students are fit for purpose and employment at the point of qualification; teaching and assessment strategies promoted the integration of theory and practice; inter-professional learning was supported in practice settings and high quality learning resources were available. Good practice included placement facilitators, who had a significant role in supporting mentors and assessors in their role with students; problem-based and enquiry-based teaching and learning strategies promoted critical thinking and analytical skills; innovative placement opportunities in non traditional settings and effective continuing professional development and work based learning programmes. Weaknesses included high attrition rates; limited opportunities for patient and client involvement; insufficient mentor/practice assessor training, support or updating and ineffective feedback to students in some programmes (QAA, 2007c). These reviews are directly relevant to the context of this thesis. They are evidence based and large scale, covering all relevant programmes in England and sampling a diverse range of practice placements. The outcomes of these reviews confirm the importance of practice learning and the vital role of mentors and practice teachers in promoting that learning. They also support the aim of this research, which is to explore the role of patients and clients in student learning in practice settings.

Cope, Cuthbertson and Stoddart (2000) interviewed nurses immediately after completion of their education programme and reported that they perceived placements to be: “complex social and cognitive experiences” (p.850). Cope et al. (2000) also concluded that practice learning is situated within the specific context and that mentors should be aware of the importance of the professional and social incorporation of students into the practice area. This supports the findings of a previous research study (Brereton, 1995)

involving interviews with lecturers, mentors and students. All three groups viewed the socialisation of students into the practice area as being of greater importance than the theory taught in college. Nolan (1998) conducted a small scale, descriptive study exploring student nurses' experiences of their practice placements. She concluded that learning was closely related to feeling part of the team and reported that students' relationships with their mentors and other staff, as part of 'fitting in', has a major impact. Paterson (1997) and Papp, Markkanen and Von Bonsdorff (2003) address the socialisation of students into the practice area, arguing that learning is more effective if students feel part of the team and are actively involved in activities.

Socialisation is well recognised as an influence on students within professional education and is said to have a major impact on the values and behaviours of practitioners (Mackintosh, 2006). There are a large number of papers addressing this issue from the 1970s. For example Davis (1975) described stages by which student nurses were integrated into the norms and values of the profession. The literature describes both positive and negative effects of socialisation on both students and on the care delivered. Greenwood (1993a) describes the desensitisation of some student nurses and Manninen (1998) refers to the loss of idealism. Indeed, following a recent qualitative study with student nurses, Mackintosh (2006) reported that the dichotomy between the caring ethos of nursing and the professional socialisation process actually inhibited their ability to care. This is an important consideration for professional programmes, given the emphasis on practice learning and the rapidly changing environments in which this is experienced.

Chan (2001) developed a tool to assess the learning environment for student nurses and reported that the practice area is a complex social entity where students, practitioners

and teachers all need to understand the social climate if learning is to be effective. This study has been replicated in other settings, with similar findings. For example, Henderson, Twentyman, Heel and Lloyd (2006) completed a large scale study in Australia and reported that the key components of successful practice areas were consistency of staff, the establishment of relationships and the integration of students into the team. Midgely (2006) also used the same tool and concluded that students would prefer an environment with increased levels of individualisation, innovation in teaching and learning strategies, student involvement, personalisation and task orientation. The replication of Chan's study in a range of settings adds to the evidence that practice areas are complex organisations and that the social integration of students into these organisations is an important factor in their learning. Levett-Jones, Lathlean, Maguire and McMillan (2007), following a critical review of psychological and social science literature, use the term 'belongingness' to explain this concept and they conclude that further research is needed to explore its impact on students' practice experiences.

It is evident that the placements accessed by health and social care have become increasingly diverse and complex since the modernisation of health and social care. Professional programmes need to embrace this diversity; to prepare students for roles in non-traditional as well as traditional settings. Despite the increasing complexity of practice experience, quality reviews indicate that this remains largely positive. The literature reviewed above largely comprises small scale studies, which are context specific. However, it is interesting to note that they all reach similar conclusions in relation to the importance of the complexity of the practice environment and of students' social integration into the practice area.

4. Facilitation of Learning in Practice Settings

The chapter continues with a review of the literature relating to the practitioners who are responsible for the support, teaching and assessment of students in practice settings. Lambert and Glacken (2004) reviewed the literature in relation to student support in practice and concluded that there is currently ambiguity in roles and they recommend that clearer information needs to be available in relation to the responsibilities of the practitioners involved. The main roles identified in the literature in relation to nursing, midwifery and social work students are the link lecturer, mentor and practice teacher, which will now be explored further.

Facilitation of learning in practice settings is the responsibility of academic lecturers; all students; mentors (for nursing and midwifery students); and practice teachers (for social work students). A recent qualitative study of nursing education in Wales (Carnwell, Baker, Bellis and Murray, 2007) identified that mentors and lecturers occupied different positions on a theory-practice continuum, with mentors focusing largely on practice and lecturers on the theoretical aspects of programmes. It is important for practitioners and academic lecturers to work together to provide the best opportunities for practice learning (Jackson and Mannix, 2001; Welsh and Swann, 2002).

Recently, new roles have emerged to support student learning in practice, including clinical practice facilitators who are employed by either NHS Trusts or by Strategic Health Authorities, with a remit to develop learning environments and to support both mentors and students. Clinical practice facilitators also have responsibility for quality assurance and enhancement, to ensure that practice areas meet professional requirements. Several evaluative studies have demonstrated their effectiveness in

promoting student learning (Clarke, Gibb and Ramprogus, 2003; Drennan, 2002; Ellis and Hogard, 2001). These studies all focus on students' perceptions of their learning and no empirical evidence was identified in respect of measurable outcomes of that learning. These roles are increasing adopting a multi-professional remit within health care and are funded by Strategic Health Authorities. However, despite the government agenda for integrated health and social care, and the corresponding inter-professional intentions of education programmes, their remit does not include social work students.

Programmes of preparation, for facilitators of student learning in practice, vary considerably between professional groups. The NMC (2008a) clearly outline standards for the preparation of mentors, practice teachers and teachers and they quality assure universities and practice placements against these. In contrast, the GSCC has produced guidance for student supervision in practice (GSCC, 2002b) and does not specify preparation requirements. For example, to improve the preparation of assessors in new placement areas within the voluntary and independent sectors, Skills for Care and the Practice Learning Taskforce commissioned a two-day training pack for these organisations to use (Beverley and Coleman, 2005). In contrast, the minimum preparation to assess nursing or midwifery students requires an academic module with completion of practice outcomes (NMC, 2008a).

Emerson (2004) mapped the competencies for professionals responsible for student learning in nursing, medicine, occupational therapy and social work. He identified common categories of: enabling learning; knowledge of the theory and principles of learning; ability to manage the learning environment; ability to impart a sense of professional responsibility; and up to date knowledge of the profession and related

curriculum. Emerson (2004) concluded that only the final category was profession specific and argued that common preparation programmes for practice educators would enhance interprofessional learning and working in practice. In the light of this mapping exercise, it is surprising to note the findings of the recent D. H. funded project which set out to develop an interprofessional programme to prepare health professionals for their roles in student learning and assessment in practice (Making Practice Based Learning Work, 2007; Mulholland, Scannell, Tumock and Gregg, 2005). The project team reviewed the requirements of dietetics, nursing, occupational therapy, physiotherapy and radiography professions and concluded that the differences precluded a joint preparation programme. They reported that all professional regulatory bodies had specific (but different) requirements relating to practice learning and that all had programmes of preparation for practice supervision, but these varied in length and content. They identified differences in titles, responsibilities, accreditation and recognition of roles within organisations and also noted that although all professions advocate interprofessional learning this was problematic in practice settings.

The project team did not conduct any empirical research, but they published case studies and identified resources for good practice in relation to teaching and learning in practice. They also recognised the need for formal preparation and reward of the mentor/practice teacher role to improve the quality of practice learning support (Mallick and McGowan, 2007). However, it is interesting to note that despite the numerous policy documents which promote inter-professional working, this is not applied to the preparation of health and social care professionals responsible for student learning in practice. It is also disappointing that this review did not include social work professionals, particularly given the government agenda for integrated health and social care.

Despite the different roles identified to support students from nursing, midwifery and social work programmes, the literature has a common theme in relation to the importance of the relationship between the student, lecturer and mentor/practice teacher. Lofmark and Wikblad (2001) used weekly diaries to explore students' perceptions of facilitating and obstructing factors in relation to learning in practice. Content analysis identified facilitating factors to include responsibility and individuality, opportunities to practice tasks, receiving feedback, perceived control of the situation and understanding the total picture. Obstructing factors included ineffective supervision, lack of continuity of supervision and lack of opportunities to practice. Factors that contribute to effective practice teaching are reported as: teaching ability; professional competence; personal qualities; acting a good role model; and effective interpersonal relationships (Knox and Morgan, 1985; Morgan and Knox, 1987). These have been confirmed by studies replicating the original research and using the same rating scale (Kotzabassaki et al., 1999; Li, 1997; Nehring, 1990). Lee, Cholowski and Williams (2002) also replicated this research and they report that both students and teachers rated interpersonal relationships as the most highly valued characteristic.

For effective learning to take place, lecturers, mentors and practice teachers must provide a safe learning environment for the students to feel integrated and involved within the team. It is important that students perceive the practice area as a safe environment in which to learn, to minimise the potential stress associated with practice experience (Timmins and Kaliszer, 2002). Parker (2006) suggests that practice is effective in promoting students' self-belief and that this can be used to challenge and extend competence. Within practice areas, lecturers, mentors and practice teachers promote the development of effective learning environments through interprofessional

working and contributing to curriculum development, to maximise learning opportunities for students. Students reported that planned learning opportunities within practice had a positive influence on their perception of the placement (Metcalfe and Mathura, 1995). It is possible to control the learning environment within the classroom setting, but within practice there are more uncontrolled stimuli creating challenges for the mentor in facilitating student learning (Papp, Markkanen and Von Bonsdorff, 2003).

Spouse (Spouse, 2001a; 2001b; 2003; Spouse and Redfern, 2000) has published widely in relation to student nurses' experiences of learning in practice settings, initially reporting the findings of her phenomenological study (Spouse, 1998) which identified that mentorship was the most important factor in student learning and their ability to relate to colleagues. Spouse advises that students value a partnership approach to this relationship with exchange of ideas and knowledge rather than the traditional teacher student model. As stated earlier, this has implications for roles of lecturers, mentors and practice teachers in relation to potential power imbalances in relationships with their students. This is supported by Gillespie (2002) who used unstructured interviews and focus groups to explore the influence of the relationship between students and their teachers. She concluded that both personal and professional dimensions are important aspects and advises that teachers should consider their role and the power balance in the relationship and, that by becoming connected to the students, they can influence professional socialisation and encourage knowledge synthesis.

The consistency of the findings of a large number of small scale studies provides evidence that the relationship between students and their mentors, practice teachers and lecturers is an important aspect of practice learning which needs to be incorporated into strategies to promote learning. However, no studies were identified which provided

empirical measurement of the outcomes of practice experience, in terms of student learning.

4.1 The Role of the Lecturer in Practice Learning

The move of professional education into higher education, for nurses, midwives and social workers, also led to changes in responsibility for student learning, with lecturers focusing on the theoretical preparation and practitioners taking increased responsibility for practice-based learning (Clifford,1999). This resulted in reduced involvement for lecturers in practice settings and led to concern that they were unable to fulfil the academic and professional demands on their role (Gidman, 2001c; Gidman, Humphreys and Andrews, 2000; Humphreys, Gidman and Andrews, 2000). For example, in a large scale study, Crotty (1993a; 1993b) explored the changes in the roles of two hundred and one nurse lecturers following the replacement of the apprenticeship model with an academic programme of preparation (UKCC, 1986) in twenty five out of the twenty eight demonstration sites. She reported that the role of the lecturer became multi-faceted, with increased level, depth and specialism and this reduced the priority given to clinical involvement. This a large scale, rigorous study which provided evidence that the role of lecturers in practice settings was adversely affected by the increased focus on the academic aspects of nursing and midwifery education. Although interview data demonstrated that lecturers had a very strong commitment to their clinical liaison role, they did not consider this to include direct involvement in care, which they perceived as being the remit of practitioners. Crotty's conclusions were supported by two, later, small scale projects exploring lecturers' roles in practice. Lee (1996) interviewed nurse lecturers and reported that only thirty one percent of respondents indicated that clinical

practice was part of their role. Clifford's (1999) study concluded that nurse lecturers were concerned about role clarity, fitting into the clinical area and justifying their role in clinical practice. It is disappointing to note that, despite many publications advocating that increased priority should be given to the role of the lecturer in practice settings, the findings of a three year longitudinal study of clinical learning environments reported that: "the contribution from school based academic staff was minimal" (Lewin, 2006, p.5).

Although the majority of literature relates to nursing and midwifery education, social work lecturers have also debated their role in practice settings. Collins, Gutridge and James (1999) report that demands on lecturers' time from their education institutions have led to reduced frequency of practice visits and in some cases, abandoning visits altogether. These authors argue for the use of innovative approaches to placement support, for example video-conferencing to maintain contact with students and practice teachers. It was interesting to note the omission of link lecturers in an extensive review of practice learning in social work which was commissioned by the Scottish executive as part of the reform of social work education. Practice teachers and clients are the individuals included as the 'actors' influencing student learning in practice (Dick et al., 2002). This is indicative of the lack of published work in relation to the role of lecturers in social work practice.

There is a long standing debate in the literature reviewed regarding the importance of clinical competence/credibility of lecturers and the extent to which they should be involved in actual practice (Clifford, 1999; Goorapah, 1997; McCormack, 1995).
In 1994, Cave argued that lecturers need to establish a unique role and to retain their clinical credibility, in order to effectively integrate the theory and practice aspects of nursing programmes. This paper was recently republished by the same journal (Cave,

2005) because of its perceived contemporary relevance (Maslin-Prothero, 2005). The debate continues, with a number of papers arguing for increased clinical priority (Barrett, 2007) although, as Elliott and Wall (2008) caution, many of these arguments are based on opinion, which is not supported by empirical evidence. Williams and Taylor (2008) recently explored nurse educators' perceptions of their role in practice education and highlight a range of barriers to its effectiveness. Kelly (2007) interviewed thirty students to identify their perceptions of effective clinical teaching and concluded that lecturer knowledge, feedback and communication were the most important aspects of the link lecturer role. However, Carr (2007) conducted in-depth interviews with thirty seven lecturers and concluded that the practice aspect of their role remains under threat. These recent papers demonstrate that concerns about lecturers' roles in practice, since pre-qualifying programmes were incorporated into higher education, are yet to be resolved.

Goorapah (1997), in a small scale study, interviewed ten nurse lecturers and ten ward sisters/charge nurses and presented a descriptive account of their views. The study concluded that respondents found it difficult to define clinical credibility, but that clinical competence was consistently associated with practical performance. Goorapah (1997) suggests that, as nurse education becomes more established within higher education, this drift away from clinical practice will continue. He contends that there is a lack of consensus as to whether nurse lecturers should practice as first level nurses, specialist nurses or advanced practitioners when they are involved in clinical practice. The study indicates that there is considerable confusion in practitioners' perception of the role of lecturers in practice. Although the findings are of great interest, they need to be treated with caution due to the small sample size and the methods used, which included taking notes during interviews rather than audio-taping.

Forrest, Brown and Pollock (1996) conducted semi-structured interviews and focus groups with lecturers, practitioners and nursing students and they reported that all groups described a lack of clarity in lecturers' clinical roles. They also conclude that lecturers perceived their skills to be based in education rather than practice and they felt that practitioners were more appropriate to teach skills. The student group confirmed that practitioners were the most effective in terms of teaching clinical skills and they perceived that the lecturer's role was to support them and their mentors. However, in contrast to this view Kotzabassaki et al. (1999) emphasised the value of lecturers acting as positive role models, which assumes that they will be competent practitioners in their own right. Camiah (1998) conducted a large scale case study, exploring the role of nurse lecturers, collecting both quantitative and qualitative data over a period of fifteen months. She concluded that although lecturers reported that it was important to be credible in an area of practice, many of them felt they had become clinically deskilled. This is supported by Glossop, Hayles, Lee and Pollard (1999) who report on the findings of an action research project, in which nurse lecturers enhanced their credibility and increased student learning, by returning to practice themselves. The studies described above adopted a range of research approaches and were conducted in diverse practice settings. They contribute to the evidence that lecturers' credibility in practice has reduced since the academic focus of their roles increased within professional programmes.

The NMC recently published '*Standards to Support Learning and Assessment in Practice'* (NMC, 2008a) to raise the priority given to practice learning, to enhance student support and to improve the rigour of assessment processes. The standards require that approved education institutions employ registrants who have successfully

met the outcomes specified for teacher preparation and have recorded this qualification with the NMC. The NMC requires teachers of nursing and midwifery to be able to support learning and assessment in both academic and practice learning environments and to spend approximately twenty percent of their time supporting learning in practice settings. This may be achieved by a range of strategies including acting as clinical teacher or link tutor; preparing, supporting and updating mentors and practice teachers; taking part in practice-based action learning groups; contributing to practice development; undertaking practice-based research; and any other strategies which enable them to maintain practice knowledge and where appropriate skills. The standards reinforce the requirement that midwifery teachers need effective registration as a midwife and need to meet the practice requirements for re-registration. The GSCC (Training Organisation for Personal Social Services (TOPPS), 2002) are less prescriptive than the NMC in terms of requirements for lecturer involvement in social work placements. They state that lecturers have an important role in co-ordinating the overall learning and assessment of students throughout their programme. They also advise that lecturers need to ensure that students and practice teachers are clear about practice requirements, particularly in the final part of the programme.

The link lecturer model involves a liaison role, exchanging information between the practice area and education institution, which may help to promote understanding of the different perspectives of academic staff and practitioners (Wills, 1997). Brown, Forrest and Pollock (1998) interviewed students and reported that their primary concern was to maintain an effective interpersonal relationship with their lecturer in practice. The link teacher model promotes effective relationships between lecturers and practitioners. However, it provides limited opportunity to develop effective relationships with students during their relatively short practice placements (Humphreys, Gidman and Andrews,

2000). Again, the above publications emphasise the importance of effective relationships in practice placements and it has been argued that using the personal tutor to support students in practice would enhance this relationship but would be logistically impractical (Gidman, 2001b).

Martin and Mitchell (2001) advise that the link lecturer should have a central role in practice settings to promote learning and to challenge the theory practice gap. Koh (2002) reported that findings of a small scale study, using focus groups, indicated that students perceived that lecturers had a vital role in facilitating them to develop reflective skills in practice, to integrate theory and practice, to provide support, facilitate shared learning and to motivate them to learn in practice. However, despite students' perceived benefits of the lecturers' role in practice settings, they suggested that they needed to play a more active role. These findings are consistent with those from previous research by the author which demonstrated that students were generally dissatisfied with the support and contact that they had from lecturers during their placements. However, when lecturers had regularly visited practice areas, students valued their support and the learning strategies employed (Gidman, 2001a).

The studies reviewed above included a large scale evaluation of the changes to nursing and midwifery education (Crotty, 1993a; 1993b), a longitudinal study (Lewin, 2006), and a number of small scale qualitative research and case studies. It is apparent from the above discussion that the majority of published literature relates to nursing programmes, with less emphasis on the role of the link lecturer in midwifery and social work programmes. However, it does demonstrate a lack of clarity in the purpose and functions of the link lecturer in practice settings and indicates that many lecturers feel anxious about this aspect of their role. It is surprising to note that, despite nursing,

midwifery and social work programmes comprising extensive periods of practice based learning, the role of academic staff in practice settings is consistently reported as falling below students' expectations.

4.2 The Role of the Mentor in Practice Learning

Practice learning accounts for fifty percent of pre-registration nursing and midwifery education programmes in the United Kingdom (NMC 2004a; 2004b). It is a regulatory requirement that nursing and midwifery students are allocated to an appropriately qualified mentor during each practice placement (NMC, 2006; 2008a). The clinical learning environment has been identified as central in integrating theory with practice for students in developing clinical skills (Burns and Patterson, 2005). According to Carlisle, Kirk and Luker (1997) students cannot be expected to make this link for themselves and need mentor support to make effective links if they are to become highly competent practitioners and life-long learners. Chow and Suen (2001) identified five key aspects of mentorship: assisting; befriending; guiding; advising and counseling.

The concept of mentorship is said to have originated from Greek mythology, in which Odysseus entrusted Mentor, an older wiser friend, to look after his son in his absence (Donovan, 1990). There is no single definition of mentorship, but there is a shared contemporary understanding that it is regarded as a process in which a person who is experienced, wise and trusted, guides an inexperienced individual to develop to their full potential (Short, 2002). Concepts of mentorship today have developed over the past 20-30 years from studies of disciplines that include academia, business and nursing. It is generally agreed that there are many benefits of mentorship for the organisation, mentee

and mentor (Rosser, Rice, Campbell and Jack, 2004). Within nursing and midwifery, the term ‘mentor’ is used to denote the role of the nurse, midwife or health visitor who facilitates learning, but also assesses, students in practice.

All new mentors are required to successfully complete an NMC approved mentor preparation programme and to achieve specific competencies and outcomes. These include establishing effective working relationships; facilitation of learning; assessment and accountability; evaluation of learning; creating an environment for learning; contextualising practice; evidence-based practice and leadership (NMC, 2006; 2008a). Mentors facilitate students to develop skills in problem solving, critical thinking, decision making and reflection which are essential competencies for complex professional practice (NMC, 2004a; 2004b; 2004c). Mentor preparation programmes also enable mentors to develop their skills to facilitate interprofessional learning with students. Recent developments in nurse education are leading to greater diversity of placements within programmes, for example the ‘hub and spoke’ approach which allocates students to a specific setting whilst encouraging them to access a wide range of alternative practice experience. This is consistent with the need to prepare professionals to work in diverse health and social care settings, in line with the policy changes discussed earlier. Mentors recognise the specific requirements of practice within their own context and also enable students to understand other professional roles and how these are being developed to meet the needs of service users. For example, the learning environment for students in the community is very different from that in secondary care in relation to addressing the students’ and clients’ needs, particularly as the client becomes the host and the practitioner is a visiting guest (Thomson, Davies, Shepherd and Whittaker, 1999). This aspect of the role is becoming increasingly pertinent with the change in

focus from secondary to primary care and the involvement of a wide range of organisations in health and social care.

Early experience of mentorship is thought to be an important aspect of learning for nursing students and positively influences the development of professional roles and perspectives and facilitates their transition to practice. Students value regular contact with their mentors and the quality of mentorship they receive has a major impact on the quality of their learning during clinical placements (Higgins and McCarthy, 2005). Gray and Smith (2000) report that qualitative analysis of data from students' diaries indicated that there was a gradual distancing from their mentors as they progressed through their programme and grew in confidence, but remained a vital aspect of practice learning. Mamchur and Myrick (2003) explored the concept of conflict within relationships between mentors and their students and report that this is more prevalent than had been anticipated. Van Epps, Cooke, Creedy and Walker's (2006) evaluative research concluded that the benefits of mentorship were apparent in long term, supportive relationships. Although these small scale studies highlight the importance of effective relationships, current nursing and midwifery programmes comprise several short placements each year, to provide a breadth of practice based experience in order to meet professional outcomes (NMC 2004a; 2004b). This results in a series of short term relationships, rather than one long term relationship, between individual students and their mentors.

Promoting interprofessional working and learning involves mentors developing effective professional working relationships, within their own areas of practice and across other agencies and professions. However, mentorship can have its complexities, due to an already stretched caseload in which the practitioner has to balance student learning

needs against the demands of day-to-day workloads (Leyshon, 2005). Neary (2000) conducted longitudinal studies in relation to mentorship from the perspective of both students and mentors which confirmed the conflict between the role of mentor and assessor, and also of other commitments including management, continued professional development and delivery of patient care within the dynamic context of the NHS. Braye and Nettleton's (2007) recent multi-professional study, using questionnaires and interviews, confirms that this dual role remains an issue. These large scale studies are supported by the findings of a small scale study by Cahill (1996), who reported that students focused on the assessment role of the mentor and that this influenced relationships. In a recent study, Webb and Shakespeare (2008) confirmed the need for the assessment role of mentors to be strengthened. Although it is too early to evaluate their impact, it is anticipated that the '*Standards to Support Learning and Assessment in Practice'* (NMC, 2008a) will address concerns about lack of role clarity and inadequate preparation of mentors which have been expressed by several authors (Bewley, 1995; Davis, Davis and Burnard, 1997; Gidman and Carr, 2007; Watson, 1999). However, the NMC standards still emphasise the dual role of the mentor, in relation to supporting students and formally assessing their competence. Indeed there is an increased focus on assessment and on the mentor's accountability to assess the student's fitness for practice at the end of his/her programme.

Assessment of proficiency is a vital part of the mentor's role to ensure safe and competent practitioners at the point of registration. This involves working in partnership with other team members to assess students, provide constructive feedback and identify future learning needs. Ovretveit (1995) suggested that approaching problems as a team is more likely to produce creativity and a variety of potential solutions and would promote student learning from experience. It is, therefore, essential that student learning in

practice is a partnership approach between the student, mentor and lecturer with all accepting responsibility for their roles. In a national study, commissioned by the NMC, Duffy (2004) investigated mentors' assessment processes and she concluded that some mentors experienced difficulty in failing students. Despite this being a small scale study, the NMC were concerned about this issue and have recently strengthened the accountability of mentors in assessing student competence and proficiency at the point of registration (NMC, 2008a).

Mentors also have a responsibility to evaluate the quality of the learning environment and to critically reflect on the teaching and learning strategies they have utilised with the student during his/her practice placement. Evaluation should not be seen as a process at the end of a placement as this does not provide mentors with the opportunity to clarify suggestions and comments. It should be an ongoing process, with designated time built into the placement, to reflect on learning and to provide better understanding of the concerns of the student (Diamond, 2004).

Mentors act as positive role models for students in promoting evidence based practice. They support students to apply evidence in order to assist them in decision making to eliminate inappropriate and ineffective practices that could be potentially dangerous. However, Hamer and Collinson (1999) caution that using evidence does not guarantee that the treatment has been carried out effectively and evaluation and monitoring is still essential. Mentors must also act as role models by demonstrating effective leadership skills, through personal qualities, setting direction and delivering the service. As nursing develops in line with the increasing complexities of patient care, leadership skills are an essential component of the role of a registered nurse. Mentors face many challenges to develop students' interpersonal and management skills, working in partnership with

multi-professionals, multi-agencies and clients/patients (Carey and Whittaker, 2002; Canham and Bennett, 2002). Role modeling was identified in chapter one as an important learning strategy for students in practice settings. Literature in the previous section identified the decreasing ability of lecturers to act as role models in practice. It is, therefore, particularly important that mentors, as experienced and credible practitioners, are effective in this role.

Mentorship is a concept which remains difficult to define, but increasingly within nurse education, is seen to be a short term supportive relationship which both facilitates and assesses learning in the practice area. Mentors are experienced professionals who often experience conflict in their role due to the demands of patient care, management, student supervision and their own professional development. It is evident, from the review of the literature above, that there is a substantial body of students who perceive the mentor to be the most important factor in their learning during placement experiences.

4.3 The Role of the Practice Teacher in Practice Learning

As in nursing and midwifery programmes, undergraduate social work programmes, leading to professional registration comprise extensive practice based experience. The General Social Care Council need to satisfy themselves that curricula meet the QAA Subject Benchmark Statement for Social Work (QAA, 2000), National Occupational Standards for Social Work (TOPSS, 2002) and the Department of Health Requirements for Social Work Training (D.H., 2002). Successful completion of accredited social work education programmes leads to registration with the General Social Care Council under

the auspices of the Care Standards Act (Her Majesty's Government, 2000). The curriculum is outcome led and centres around the National Occupational Standards for social work, to ensure that students are competent to practice at the point of registration.

Social work students are supported and assessed, during their placement experience, by practice teachers and the literature highlights their vital role in promoting learning (Bhattacharya, Harwood, Hayto and Seden,1998; Billingham, 1999; Bucknell, 2000; Cartney, 2000; Kennedy, 2001). The practice teacher can be an individual within the placement itself or can be based outside the organisation, so called 'long arm supervision' (Karban, 1999). This is in contrast to the requirements for nursing and midwifery where mentors must be based within the placement organisation and must spend a minimum of twenty percent of their time working alongside students. The literature highlights the importance of practice supervisors working with the students and of ensuring effective communication with the student and academic links in the university (Dick et al., 2002). Billingham's (1999) case study of a preparation programme for practice teachers identified the value of joint working between the voluntary and statutory sectors in this project and she recommends a comparative study to explore the range practice experience which these sectors provide.

The National Organisation for Practice Teachers (2007) provide the following definition of practice teachers: "The person who has principal responsibility for organising and coordinating the practice learning opportunities and provide learning support, links between theory and practice and a professional judgement, through assessment, as to the student's competence" (p.9). Evans (1999) identifies seven major aspects of this role: enabling; teaching; assessment; taking accountability; organising placement opportunities; reflecting critically; and ensuring own support. As with mentorship, the

relationship between practice teacher and student is a key aspect in student learning (Ward, 1999). Ward (1999) argues that this learning is influenced by the way in which the student is treated; the student's perception of congruence between espoused theories and practice; understanding of the student's own frame of reference; and the extent to which practice experience is recognised within the programme.

The GSCC '*Guidance on the Assessment of Practice in the Workplace'* (GSCC, 2002b) was published in response to the strategic changes within social care delivery and social work education, as discussed in the previous chapter. The GSCC guidance for the facilitation of practice based learning in social work aims to provide a tool to improve assessment practice, but interestingly and in direct contrast to the NMC 'requirements' these guidelines are not mandatory or regulated. The publication highlights the need to standardise the practice assessment process and the preparation of assessors. It explicitly refers to adult based learning and reflective theories to underpin learning and articulates the links between workplace assessment, a competent workforce and raising standards in practice. This document provides a framework of benchmark statements and is intended to be used by training and education providers to identify the competence of social work practitioners to assess students in practice. These statements are grouped into three domains: the organisation of opportunities for students to demonstrate competence in practice; enabling learning and professional development in practice; and managing the assessment of learners in practice.

The organisation of opportunities for students to demonstrate competence in practice involves assessors accepting responsibility for the learning environment; negotiating and coordinating learning opportunities; working collaboratively with colleagues and service users; critically evaluating the placement as a learning environment; and contributing to

the development of the organisation in relation to training and learning. Enabling learning and professional development in practice involves developing effective relationships with students to identify their expectations and to meet learning outcomes; planning learning opportunities to meet these outcomes; recognising individual learning styles; making professional educational judgements about students' performance; identifying the responsibility of both students and assessors; establish a process to review learning; and encouraging students to take increasing responsibility for their own learning. To manage the assessment of learners in practice, workplace assessors must engage learners in the assessment process; agree assessment methods; and ensure that assessment is based on reliable and evidence based judgements. They must also use direct observation of student performance; promote self-assessment; peer review and involve service users and carers (GSCC, 2002b).

The model of long arm practice teaching is used regularly within social work education programmes, where there is no qualified practice teacher within the organisation. This involves students being allocated to an identified supervisor within the placement area but a qualified practice teacher links to the student and supervisor and takes overall responsibility for student learning and assessment (Karban, 1999). It is reported that there are advantages to this model in terms of objectivity, providing a relationship to discuss concerns about practice and promoting anti-discriminatory practice (Lawson, 1998). Lawson (1998) argues that the long arm practice teacher model is particularly relevant in the current, inter-professional context of social work. However, this tripartite relationship does have the potential for conflict and collusion and needs to be carefully planned, particularly in relation to roles, boundaries and confidentiality (Karban, 2000).

It is evident that there is less empirical research in relation to the roles of practice teachers in social work education, in comparison to the roles of mentors in nursing and midwifery education. Although the literature reviewed emphasises the importance of the practice teacher in promoting student learning, the role is less clearly defined and professional guidelines, rather than prescribed standards, inform practice. However, the literature is consistent in respect of the increased diversity of settings and the complexity of the roles in terms of student support, learning and assessment.

5. Conclusion to Chapter

Practice learning is central to professional education and it is a requirement that pre-qualifying nursing, midwifery and social work students spend part of their programmes of learning in practice settings (GSCC, 2002a; NMC, 2004a; 2004b). However, pressure on placement capacity, due to increasing student numbers and increased focus on practice experience within curricula, has led to concerns about the quality and quantity of placements (Brennan and Hutt, 2001; Collins and Turunen, 2006; Conway and MacMillan, 2000; Furness and Gilligan, 2004). Several pertinent issues were identified in the literature in relation to practice learning: the need for collaborative approaches between universities and service organisations; fitting in and understanding the complex nature of health and social care; and interpersonal relations with the team (Lofmark and Wikblad, 2001; Papp et al., 2003; Spouse, 1998; Welsh and Swann, 2002).

The current priorities for the modernisation of health and social care services include the integration of health and social care delivery, with inter-professional working and learning and increased emphasis on community based services across a broad range of

organisations. The implications of the modernisation of health and social care for professional programmes include diverse and complex practice placements and a requirement for effective support for students. The majority of research relating to practice learning environments comprises small scale, qualitative studies, focusing on nursing programmes. The findings of these studies are context specific and cannot, therefore, be generalised to other programmes. However, they do highlight the importance of understanding the social complexities of placements and the need for students to develop effective relationships and to integrate into the practice team. The literature reviewed also indicates that the socialisation process may have negative effects on care delivery and it is important that practitioners who are responsible for practice learning are aware of the potential implications of this.

Although differences within preparation programmes were identified in the literature, in terms of regulatory requirements (nursing and midwifery) (NMC, 2008a) and guidance (social work) (GSCC, 2002b), it is evident that there are a number of similarities between the roles of mentor and practice teacher. Both roles include student support, developing the learning environment, the facilitation of learning in practice settings and the assessment of students against specified competencies. It was interesting to note that whilst Emerson (2004) identified similarities in professional requirements for these roles, a Department of Health funded study concluded that a common preparation programme was not feasible (Making Practice Based Learning Work, 2007). This literature review supports Emerson's (1994) conclusion that an inter-professional programme would be possible and would benefit both students and practitioners. The literature also indicates that close collaboration between lecturers, mentors and practice teachers is essential in order to promote the integration of theory and practice and to maximise learning for, in and from practice experience.

The extensive body of literature reviewed in this chapter confirms the importance of practice learning and the vital role of mentors and practice teachers in promoting that learning. The literature identifies a limited role in respect of the lecturer's role in promoting learning in practice for nursing, midwifery and social work students (Cave, 2005; Lewin, 2006). The studies reviewed adopted a range of research approaches and were conducted in diverse practice settings, with the majority focusing on the role within pre-registration nursing programmes. Although mainly small scale and context specific, these studies do contribute to the evidence that lecturers' credibility in practice has reduced since the academic focus of their roles increased within professional programmes. This is surprising given the increased emphasis on practice learning within all three professional programmes.

Mentors (for nursing and midwifery students) and practice teachers (for social work students) are consistently reported in the literature as having the most influential role in student learning and assessment in practice (Dicke et al., 2002; Higgins and McCarthy, 2005; National Organisation for Practice Teaching, 2007; Spouse, 2003). The consistency of the findings of a large number of small scale studies, conducted over the past two decades, provides evidence that the relationship between students and their mentors/practice teachers is an important aspect of practice learning which needs to be incorporated into strategies to promote learning (Karban, 2000; Knox and Morgan, 1985; Lee et al., 2002; Li, 1997: Van Epps et al., 2006). However, no studies were identified which provided empirical measurement of the outcomes of practice experience, in terms of student learning. It is apparent within this chapter that there is less empirical research in relation to the roles of practice teachers in social work education, in comparison to the roles of mentors in nursing and midwifery education. However, the literature is

consistent in respect of the increased diversity of settings and the complexity of the roles in terms of student support, learning and assessment (Billingham et al., 2001; Bray and Nettleton, 2007; Lambert and Glacken, 2004; NMC, 2008a; Skills for Care, 2007). This will be discussed below in relation to the development of the research questions for this study.

This chapter has considered a wide range of literature in relation to practice settings within the contexts of health and social care and within a very broad operational definition of practice learning. It is acknowledged that this may have led to breadth, at the expense of specificity, in relation to the critical review of literature in this chapter. However, the researcher, in discussion with her supervisors, felt that it was necessary to focus on the current context of health and social care, which is no longer profession specific, to provide a true background to the research. To overcome some of the difficulties inherent within this approach, the researcher has included three chapters focusing on the extensive body of literature. The following chapter provides an in-depth of analysis of research studies relating to learning from patients and clients, although few studies were identified which directly investigated this learning in practice settings.

It is evident, from the conclusions of this chapter, that the placements accessed by health and social care students have become increasingly diverse and complex since the government modernisation agenda. Although the literature reviewed largely comprises small scale studies, which are context specific, it is interesting to note that they all reach similar conclusions in relation to the importance of the complexity of the practice environment. This diversity of placement experience reinforced the researcher's interest in the concept of complex adaptive systems in relation to the

context of this thesis. As previously discussed, systems which include human agents have additional complexity in terms of norms, values, language and narratives and the effects of these were evident in the data. The agents in practice settings include staff, patients, clients, carers and students and these potential networks need to be fully acknowledged when considering student learning in this context. It is evident from the above review of the literature that effective communication and collaborative learning are essential to promote learning in practice settings. Complexity theory's recognition of networks, relationship and connectedness are directly relevant to learning from other professionals and from patients and clients. It may also provide an alternative theory to frame the relationship between patients, clients and professionals (Cooper and Geyer, 2007), as advocated in recent policies. This chapter confirms that the current context of health and social care requires more than the traditional notion of competence as knowledge, skills and attitudes. Fraser and Greenhalgh (2001) propose complexity theory for education in the NHS, to develop capability as well as competence (the ability to adapt to change, generate new knowledge and to continuously improve performance). This led the researcher to further explore complexity theory in relation to the development of this thesis (as summarised in table 1 in the previous chapter) and to incorporate a research question to investigate its relevance to learning in the context of this study.

The review of the literature did not identify any empirical research relating specifically to learning from patients and clients in practice settings. As previously discussed, patient and client involvement in health and social care education is becoming increasingly important and the current gap in the literature supports the aim of this research, which is to explore the role of patients and clients in student learning in practice settings. Although the majority of research comprises small scale studies, these provide evidence

of the complexity of practice experience and of the importance of relationships in the learning process (Dick et al., 2002; Gidman, 2001a; Lewin, 2006; Spouse, 2003; Van Epps et al., 2006). It is also evident from the literature that a range of individuals are involved in facilitating student learning for, in and from practice experience, including lecturers, practice teachers, mentors and other members of the practice team (Bray and Nettleton, 2007; Carnwell et al., 2007; Webb and Shakespeare, 2008). However, there was limited reference to the strategies to promote this learning. These conclusions led to the following research questions:

- What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements?

- How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

- What teaching and learning strategies are used to promote learning from patients and clients in practice settings?

Chapter 3: Patient and Client Involvement in Health and Social Care Education: a Critical Review of Policies and Literature

1. Introduction to Chapter

This chapter will critically review the literature relating to patient and client involvement in health and social care programmes. This will be discussed in relation to the following main themes extrapolated from the previous chapters:

- Government and professional policies promote integrated services and inter-agency working; this requires health and social work education to incorporate inter-professional learning opportunities;
- Government reforms to the NHS and Social Services have implemented a target driven approach to care; this has led to a competence driven approach to education programmes;
- Professional education programmes adopt an andragogical, student-centred approach and incorporate both academic and practice based learning and assessment;
- A central theme of the government reforms is public involvement in all aspects of service design and delivery; there are corresponding professional requirements for involvement in nursing, midwifery and social work education.

It is evident from the previous review of government policy in relation to health and social care policy that there is a continuing commitment to reform services by: increased public involvement in service design, delivery and evaluation; improved choice and availability

of services for all service users; reducing inequality; emphasis on local, community based provision, including voluntary and independent sectors; the commissioning process; integrated health and social care; and professional roles to deliver care based on service user need. These reforms require the blurring of the boundaries between professionals employed in health and social care; increased inter-professional and inter-agency working; and change in culture within organisations to increase the power base of the public in all aspects of provision. Health and social care professionals need to be responsive to the constantly changing needs of all service users, this requires the development of practitioners who will positively influence care for patients, clients and service users. This necessitates an emphasis on patient/client/service user centred care and their increased involvement in all aspects of education planning, delivery and evaluation.

The literature reviewed in the previous chapter indicates the need for lecturers, mentors and practice educators to be actively involved in facilitating learning during practice placements. There is a need to clarify their respective roles and to develop effective strategies to promote this experiential learning, including their roles in promoting learning from patients and clients. Practice learning should provide the obvious learning opportunities for students to learn from patients and clients, but this has occurred in a largely *ad hoc* manner in the past (Gidman, 2001a; 2001b). Patient and client led organisations are committed to playing a more active role in providing learning opportunities in practice settings (Practice Learning Taskforce and D. H., 2003). This includes preparation for placements, learning opportunities within these organisations, and maximising learning opportunities within practice settings.

Although it is now a professional requirement that nursing, midwifery and social work programmes embrace patient and client involvement, there is currently a range of approaches adopted in health and social care education. These may be viewed on a continuum from 'tokenistic' inclusion in teaching sessions to a fully inclusive, empowerment approach where participants' involvement is as equal partners in all aspects of the education process.

This chapter critically reviews the literature relating to patient and client involvement in health and social care programmes. This includes a critical evaluation of government and regulatory body policies which drive the patient involvement agenda in professional education. A central theme of the government reforms is public involvement in all aspects of service design and delivery. There are corresponding professional requirements to involve patients and clients in nursing, midwifery and social work education. As in the previous chapter, a systematic review of the literature was conducted using the same databases, professional and government websites. The following search terms were used to identify relevant publications: client and involve; patient and involve; service user and involve; women and involve; client and learn; patient and learn; service user and learn; women and learn; client and teach; patient and teach; service user and teach; women and teach. In addition, the researcher attended a regional group which was promoting patient and client involvement in health and social care education programmes.

A large number of publications were accessed in relation to patient and client involvement in health and social care education. However, the majority of these were discussion based papers. It is evident from this literature review that there are relatively few research based studies, and that these mainly comprise small scale, case study

approaches which evaluate local projects. However, these studies are generally not outcome focused and many lack the necessary rigour to judge whether partnership working with patients and clients makes a difference. Twenty six research studies were identified from the numerous papers reviewed and these are summarised in Appendix 1. Although there remains a lack of empirical evidence relating to patient and client involvement in health and social care education, these studies do contribute to the growing body of knowledge.

Eight main themes were extrapolated from the publications accessed and these will be used to structure the literature review which follows:

- Partnership with patients and clients
- Surveys of current practice
- Programme planning
- Teaching
- Structured dialogue
- Assessment
- Stakeholder perceptions
- Consumer academic roles

2. Partnerships with Patients and Clients

The contemporary government and professional policies discussed in chapter one, act as the major drivers for partnership working within health and social care and their associated education programmes. However, despite this clear intent to promote

partnership working, the concept itself is not consistently defined or applied. It is often used interchangeably in the literature to refer to the terms collaboration, cooperation, multi-disciplinary, interdisciplinary and interprofessional (Barr, Freeth, Hammick, Koppel and Reeves, 2000). In relation to patients and clients, the concept of partnership also incorporates a range of different terms for example participation, involvement and empowerment which have implications for the nature of the relationship (Ager, Dow and Gee, 2005). This was a large scale study comprising questionnaires and focus groups with practice teachers, clients and students involved in social work programmes in the United Kingdom.

It was interesting to note that a recent summary of reviews of the quality of learning, in health related programmes, identified effective partnership working as a strength, but did not define the concept of partnership itself (QAA, 2007a; 2007b; 2007c). Taylor et al*.,* (2006) report the findings of a large scale survey of social work programmes in the United Kingdom, which was supported by questionnaires, telephone interviews and focus groups. This survey explored the concept of partnership in general and did not focus specifically on clients. The researchers concluded that two main approaches were evident in practice; that is, the embedded approach in which partnership education is integrated into the curricula and the discrete approach, where specific modules focus on partnership. They also report that thorough integration of clients in programme structures, processes and content is not well developed. Taylor (2006b) reports on this study and concludes that the concept of partnership needs to be theorised in a range of contexts and that effective strategies need to be developed to improve the quality of partnership working within health and social care service and education. The research team was aware of the significance, in professional practice, of tacit knowledge but they acknowledge that this was not necessarily accessible via their methodology. The

importance of alternative forms of knowledge was identified earlier in this thesis (Benner, 1984; Eraut, 1994; 2000; 2004) and will be explored further throughout this thesis.

Social work education has a longer history of client involvement than health education (Beresford, Page and Stevens, 1994; Croft and Beresford, 1993; Harding and Oldham, 1996; Turner in “Shaping Our Lives National User Network”, 1998). However, the literature indicates that there is currently an inconsistent approach to this involvement across social work, nursing and midwifery programmes. Partnership work with clients in social work education emphasises students’ understanding of their experience, particularly in terms of recognition and of anti-discriminatory practice (Elliott et al., 2005; Jackson and Morris, 1994; Scheyett and Diehl, 2004; Shor and Sykes, 2002). Although the policies relating to nursing and midwifery also recognise patients’ experience, they tend to focus on expert knowledge rather than anti-discriminatory practice (Hope, Pulsford, Thompson, Capstick and Heyward, 2007; Warne and MacAndrew, 2005; Wood and Wilson-Barnett, 1999).

Guidance for the commissioning of mental health programmes has been influential in promoting patient and client involvement (Brooker, James and Readhead, 2003; Northern Centre for Mental Health, 2003). However, a survey commissioned by the National Institute for Mental Health in England, identified that although progress towards involvement was considered important by education providers it was inconsistent in its implementation (Tew, Gell and Foster, 2004). Levin (2004) was commissioned by the Social Care Institute for Excellence (SCIE) to produce a guide for education providers in social work education in respect of client involvement and partnership. She reports a lack of consistency in the progress made towards this across education providers with some examples of excellent practice, for example, in mental health education (Molyneux,

2001; Simpson, 1999) and others who have very limited engagement with the process to date. The guide was produced in consultation with national bodies, key stakeholders and client groups. Levin argues that client involvement in both the design and delivery of the social work degree has the potential for students to gain a thorough grounding in their experiences and expectations. She contends that priority should be given to building capacity in both education providers and client organisations to develop effective partnerships and advises that this requires ring-fenced funding. Issues which need to be addressed include training programmes for clients and the payment of individuals for their involvement (this currently has implications currently in terms of the benefit system). Codes of practice on client participation are recommended to promote consistency across organisations and the effectiveness of initiatives need to be robustly evaluated (Levin, 2004). The papers by Tew et al. (2004) and Levin (2004), although not reporting on empirical research studies, do provide comprehensive surveys of practice in the United Kingdom to inform health and social care education programmes.

Clients are aware of the power imbalance inherent in social work education programmes and this leads to them feeling disempowered (Allain et al*.,* 2006). This view is supported by Baldwin and Sadd (2006) who report that clients who were involved in both theory and practice elements of social work education programmes acknowledged the power imbalance in their roles. It is evident that universities need to be clear from the start about the levels of participation intended within involvement, including the power and influence that stakeholders have in decision making. This inconsistent approach is mirrored in health programmes. O'Neill (2005) reports on an audit of current curricula in pre-registration nursing and midwifery education and concluded that patient involvement was most developed in mental health, learning disability and midwifery programmes and least well developed in adult branches. Although the above publications are not

research based, they raise interesting issues in relation to the potential power imbalances which need to be addressed if patient and client involvement is to be meaningful in practice.

From a historical perspective Balint (1964) is attributed with first describing the concept of patient centredness (Warne and McAndrew, 2005). He applied Rogers' person-centred counselling approaches to health care and proposed the notion of patient-centred care. Tuckett, Boulton, Olson and Williams (1985) also recognised the need to move from a bio-medical approach to care, to a more holistic approach in which the patient's subjective experience is valued. They concluded that patients were experts on the story of their own illness and cultural and personal history. Patient-experience knowledge requires the professional to view the patient as a whole person not as a condition. Patient-experience knowledge was discussed in chapter one and it was suggested that patient stories may be a strategy to promote student learning from this. It was also suggested that complexity theory may provide an alternative theoretical perspective to replace the traditional rational scientific approach to medicine and to value this form of knowledge (Griffiths, 2002; Sweeney, 2006).

Warne and McAndrew (2005) contend that the traditional view that theoretical knowledge is the most important should be challenged and they argue that theory arises out of practice and should not be divorced from it. Consequently, they contend that education programmes should be shaped by practice and include the lived experience of patients within this practice. Skidmore (2005) discusses the role of the professional and argues that "the expert should use their expertise to facilitate another's journey; be it through health, education or the workplace. To do otherwise

removes control from the individual and makes them forever dependent on the expert" (p.25).

Rolfe (2005) proposes that the drive to increase patient involvement in nurse education programmes is an attempt to initiate a paradigm shift. He argues that this involves moving from a positivist view of the world to a constructivist one, with a corresponding shift from an educational model based scientific knowledge to one based on narrative knowledge. He cautions that "the patient is not an open book to be read; the patient experience is constructed and shaped through dialogue; it is only in the sharing of the experience that it is (trans)formed into knowledge" (p.xiii).

This is consistent with the empowerment perspective and paradigm shift in health and social care, which was discussed in chapter one and which informs the conduct of this thesis. However, Warne and McAndrew (2005) propose that the current context of health care settings disadvantages both students and new nurses who have less experience than expert professionals. They argue that the current context of healthcare maintains the status quo and is the means by which the professions perpetuate themselves. This has relevance to this research study which aims to explore students' perceptions of their learning experiences involving patients and clients in the practice setting. It is evident that students' experiences of learning cannot be viewed in isolation from the culture of the environment in which that learning takes place. This concept will be explored further in chapters six and seven in relation to the research findings.

Models of participation based on human rights, equalities, inclusion and the social model of disability seek to empower people and to address discriminatory and oppressive practice. Beresford (2003) contends that the most effective model of participation is that

of direct transmission of people's experiential knowledge in research and training. He argues that the interpretation of this experience by a third party may lead to unreliable and distorted knowledge. This is consistent with the philosophy underpinning this thesis: that is, to use descriptive phenomenology as both a research philosophy and method to describe the experience of individuals in their own language without interpretation by the researcher (Giorgi, 1989b).

Turner in "Shaping Our Lives National User Network" (2002) advise that patient and client involvement should be planned and structured and should be based on true partnerships. He also argues that universities should work with organisations that are controlled by patients and clients, criticising the common practice of linking with individuals who may not represent a wide range of views. However, Skidmore (2005) contends that where individual patients are involved in teaching and learning there is a danger that they collude with the experts to maintain the status quo. It is interesting to note that work published thirteen years ago (Beresford et al., 1994) raised many of the issues which are still highlighted as concerns in contemporary literature. Beresford et al. (1994) argue that clients should have equal standing with other expert perspectives in social work education and that education, payment and support issues should be addressed. As will be explored later in this chapter, there is a need to address organisational culture and systems if partnership with patients and clients is to be effective.

Goss and Miller (1995), Forrest, Brown, Risk and Masters (1998) and Forrest, Masters and Brown (2000) all used models of involvement adapted from Arnstein's (1969) ladder of participation. These models included: no involvement; passive involvement; token involvement; collaboration; and partnership/total systematic involvement. Forrest et al.

(1998; 2000) interviewed mental health patients, using a grounded theory approach and concluded that levels of involvement need to be clarified and agreed to enable effective strategies for implementation. The majority of partnership work described in the literature in relation to patient and client involvement in health and social care is at the lower end of these continuums and includes consultation and curriculum involvement.

However, many authors advocate for partnership working at the other end of the continuum embracing true partnership with shared action, influence on outcomes and systematic involvement (Ager et al., 2005; Elliott et al., 2005; Scheyett and Diehl, 2004). Whilst Barnes, Carpenter and Bailey (2000) see partnership as the dominant focus for patient and client involvement, with empowerment as an outcome rather than a primary aim, others view empowerment as the value underpinning the whole approach (Braye, 2000; Braye and Preston-Shoot, 1995; Kemshall and Littlechild, 2000). Indeed, it may be argued that empowerment should be a condition of engagement laid down by potential patients and clients (ATD Fourth World, 2003a; 2003b).

Scheyett and Diehl (2004) argue that partnership and empowerment should be at the core of social work education to reflect the values of the profession. They contend that partnership working in professional education has benefits to clients, because it develops social workers who are more responsive to their needs. Several authors report that patients and clients appreciated being involved in professional education programmes and felt valued and recognised as a result of this (Boylan, Dalrymple and Ing, 2000; Connolly and Novak, 2000; Curran, 1997; Scheyett and Diehl, 2004; Scheyett and Kim, 2004). However, the literature reviewed whilst supporting this stance, provides insufficient empirical evidence at present to support this claim.

Although a large number of papers were identified which addressed partnership working in education programmes, there were relatively few research studies which specifically related to partnership working with patients and clients and these did not directly address outcomes in terms of change in actual practice (Ager et al*.,* 2005; Forrest et al., 1998; 2000; Jackson and Morris, 1994). The studies that were identified focused mainly on classroom learning rather than learning in practice settings, although it has been argued that practice placements provide a better opportunity for learning about partnership than taught models (Jackson and Morris, 1994). The lack of literature relating to the formal involvement of patients and clients in practice based learning is surprising in the light of the current focus on this within professional curricula and quality monitoring mechanisms (GSCC, 2002a; NMC, 2004a; 2004b; 2006, Skills for Care and Development, 2007; QAA, 2007a; Skills for Health, 2006; 2007). However, it is interesting to note that the papers exploring this issue were some of the more recent publications, which may be an indication that this an area of increasing interest. This is appropriate to this research study which is intended to add to an increasing body of knowledge in this field.

This chapter will continue with a critical review of the literature relating to patient and client involvement in health and social care education. As previously stated, there were relatively few research based papers and those that were identified comprised small scale projects which were context specific.

3. Surveys of Current Practice

One of the most comprehensive studies reviewed was reported by Taylor et al. (2006), although the survey described rather than evaluated current practice. They conducted a research review and practice survey in relation to partnership working in social work education and reported “conceptual hybridity and confusion” (p.xi) in relation to partnership. Their findings indicated that two main approaches were evident in practice; that is, the embedded approach in which partnership education is integrated into the curricula and the discrete approach, where discrete modules focus on partnership. The data also indicate that thorough integration of clients in programme structures, processes and content is not well developed and clients warn of the potential for tokenism when they are invited to participate but too minimally to make a real impact on student learning. The practice survey included documentary analysis of thirty three programme handbooks (forty one percent of programmes contacted), fourteen telephone interviews with academic staff and focus groups with students, staff and clients. It is interesting to note that data from the interviews indicates that partnerships in practice learning were contradictory and dependent on the commitment of individual practitioners and organisations, although there was agreement that client involvement should start as early as possible in curriculum planning and delivery. Time was identified as a major factor in promoting or restricting partnership working in practice. There was a strong link identified between partnership working and promoting anti-discriminatory practice. Although there is an assumption that students learn from clients in practice settings, there were no examples of partnership curricula to promote this in practice learning. The practice survey identified that partnership working with clients in student assessment is under developed although it was reported that this would empower users and carers and provide a valuable source of feedback for students. Taylor’s (2006b) paper, based on

this study, concludes that the concept of partnership needs to be theorised in a range of contexts and that effective strategies need to be developed to improve the quality of partnership working within health and social care service and education.

Ager et al. (2005) report on a Scottish Institute for Excellence in Social Work Education (SIESWE) funded project to develop good practice guidelines for client involvement in social work education programmes. Data was obtained through questionnaire responses from one hundred and twenty practice teachers and forty six students and through six focus groups, involving twenty eight clients. They used an adaptation of Arnstein's (1969) '*Ladder of Participation'* to analyse data and concluded that clients in this study were 'involved', 'informed' and 'consulted' which are all at the lower rungs of the ladder. However, they contend that participation should involve 'influence on action', which is at the upper end of the ladder. As previously discussed, this was a large scale rigorous study which provides evidence that partnership working is currently at the lower end of the continuum. The resulting guidelines emphasise agreed values and levels of understanding to promote involvement that extends beyond tokenism (Ager et al., 2005).

The conclusions of Ager et al. (2005) are supported by the findings of research by Molyneux and Irvine (2004). They present a survey of Approved Social Worker programmes in England, involving documentary analysis and focus groups with client groups. They also describe a continuum of client involvement: no involvement, passive involvement, limited two-way communication, listening and responsive and partnership. All nineteen programmes involved clients and sixteen involved carers in teaching sessions; fourteen of the programmes involved them in programme boards; seven in monitoring and evaluation. Clients felt that they could be more involved in programme

delivery, assessment and evaluation, but the data indicated that involvement was largely at the lower end of the continuum.

Julia and Kondrat (2000) used a content analysis research design to review seventy five of the total one hundred and twenty five social work programmes in the United States in relation to the teaching of research and concluded that participatory research was not evident in the majority of cases. The researchers acknowledge that the findings are limited to programme documents and may not reflect the actual content or perspectives of individual lecturers. They argue that their findings are at odds with the emphasis and professional expectation of collaboration in work with clients. Patient and client involvement in research is a growing area of interest (UK Mental Health Research Network, 2007) and guidance has been developed to promote this (Joseph Rowntree Foundation, 2005). A recent publication was identified in the UK, which describes the involvement of learning disability clients in research projects (Gilbert, 2004).

Several interesting papers were reviewed which, although small scale, case study reports as opposed to extensive surveys, demonstrated the integration of patient and client involvement with contemporary andragogical approaches to professional education. Rush and Barker (2006) brought together client involvement and enquiry based learning in pre-registration nursing in the United Kingdom. This was positively evaluated by students and the authors recommend comparative studies between enquiry based learning with and without patients and clients. Huntington (2006) successfully integrated clients' perspectives into an e-learning project in social work education in UK and Porter and Hayward (2005) report using the Caldicott principles (D.H., 1997) to ensure patient confidentiality in a client involvement project.

A range of issues was identified in the literature including the training and support of clients, payments for their contribution and organisational constraints. Training and support of clients is recognised as vital to the successful implementation of their involvement in health and social care education. There are currently a number of preparation programmes in use (Central England People First and Smith, 2003; Gell, 2003; Gell and Seebohm, 2001; National Institute for Mental Health in England, 2003b). Payments for patients and clients who are involved in health and social care education is a contentious issue. Whilst the principle of payment is widely accepted, there is a wide range of approaches actually in use, for example payment as visiting lecturers, payment at rates negotiated by participants' organisations, limited payments, payments in kind and reimbursement of expenses. There are also unresolved issues in terms of the impact payments may have on participants' benefits which is the subject of lobbying by patient and client groups (Scott, 2003). Other potential issues to be addressed include confidentiality, possible atypical representation and labeling according to individual patient's or client's role, rather than their true holistic identity (Levin, 2004; Manthorpe, 2000).

It is evident from the above surveys, which describe current practice in health and social care education programmes, that there are a range of approaches to patient and client involvement and that, currently, these are largely at the lower end of the partnership continuums discussed earlier.

4. Patient and Client Involvement in Programme Planning

A number of papers relate to the involvement of patients and clients in planning programmes for health and social care education. Forrest et al. (1998, 2000) used focus groups to explore thirty four service users' views of the knowledge, skills and attributes needed by mental health nurses in the UK, to influence curriculum development. They used a grounded theory approach to analyse the data and identified themes in relation to conflict between professional and service user views. The researchers also reported that the nature of involvement, from tokenism through to true partnership, needs to be agreed and they acknowledged that individual clients are not representative of the whole population. Masters et al. (2002) report the evaluation of the second phase of the same project which devised a strategy for client involvement and simultaneously evaluated the strategy development process, by means of questionnaires distributed to thirty three stakeholders. Qualitative and quantitative data indicated that the project was viewed positively by students, lecturers and clients, but the researchers acknowledge the omission of practice mentors from the collaborative project. The emotional aspect of involvement and the time and enthusiasm required were highlighted as central to the process. These two studies, although related to a specific mental health programme development, provide evidence that clear strategies are required in order to develop meaningful partnerships and to avoid tokenism in the involvement agenda.

Other papers were identified in relation to programme development but were considered as descriptions of individual initiatives, as opposed to research, and are, therefore, not included in the summary of research evidence. A Department of Health consultation exercise provided evidence that clients, across a range of groups, agreed on the personal qualities, skills, abilities and knowledge required by health and social work

professionals (Swift, 2002). Clients reported that social workers should be supportive, encouraging, respectful, attentive, committed to the independence of the individual, trustworthy, reliable, punctual, physically and emotionally available, empathic and warm. Fraser (1999) interviewed forty one women in the UK, during and after pregnancy and analysed their records, to explore their views of midwifery care and used their responses to influence curriculum delivery and to promote women centred care. A similar consultation exercise was conducted by Stevens and Tanner (2006) to inform social work curriculum development. Focus groups with clients identified two key issues for social work training: the need to understand life from the client's perspective and the importance of the relationship between client and social worker. Alexander and Heggerty (2001) involved a learning disability client and his key worker in programme planning meetings and both reported positively on the level of involvement achieved. Although this is a small scale project, it does provide an example of involvement of a service user who needed extensive support to contribute to the process.

Although the value of patient and client contribution to curriculum development is demonstrated, these papers refer to projects involving consultation and attendance at working groups and only provide evidence of partnership approaches at the lower level of the continuum of participation.

5. Patient and Client Involvement in Teaching

Patient and client involvement in teaching and learning provision is the aspect with the longest history in health and social care education. There were a number of papers which reported positive evaluations of projects to include patients and clients in

programme delivery (Barnes, Carpenter and Bailey, 2000; Barnes, Carpenter and Dickinson, 2006; Carpenter, Barnes and Dickinson, 2006; Costello and Horne, 2001; Hanson and Mitchell, 2001; Masters et al., 2002; Price, 2004).

A range of publications describe projects which indicate that mental health clients are willing to participate in student learning and that both clients and students believe this participation to be valuable (Edwards, 2000; Felton and Stickley, 2004; Fisher, Gibbon, Kennedy, Benson and Waterhouse, 2005; Forrest et al*.,* 2000; McAndrew and Samociuk, 2003; Morgan and Sanggaran, 1997; Reynolds and Read, 1999). Patient and client involvement in other aspects of health education is less well published but includes cancer services (Daykin et al*.,* 2002); child nursing (Price, 2004) and midwifery education (Fraser, 1999).

A number of papers offer examples of patients and clients presenting their experiences to students in classroom settings (Boylan et al., 2000; Brandon and Knapp, 1999; Curran, 1997; Gonzales, Gangluff and Eaton, 2004; Manthorpe, 2000; Pickering and Mullender, 1991). The objectives of this involvement are largely to inform and develop students' understanding in relation to patients', service users' and carers' experiences and views, to challenge stereotypes, promote communication skills and inclusive behaviour and to consider their own roles and status.

In addition to the above descriptive papers there are a number of programme evaluations reported in the literature, which although small scale and context specific, add to the consensus that patient and client involvement is viewed positively by all stakeholders. Hanson and Mitchell (2001) used a questionnaire and nominal group technique to evaluate a five-day course which involved patients in teaching sessions for

nine mental health students. The data indicated that students were positive about the course although there were no comments directly related to learning from patients. However, post-course evaluation after six months did indicate that it had facilitated participants to subsequently become involved in a range of patient issues. The researchers claim that such local initiatives have the potential to empower clients but no data is presented to support this. Costello and Horne (2001) report a small scale study which explored the participation of three patients in classroom teaching of twenty three adult pre-registration student nurses; this is one of the few studies identified which focuses on adult nursing programmes. Students evaluated the sessions by questionnaires and reported that they provided valuable insights into patient experience. All three patients indicated that they had benefited from their involvement, welcoming the opportunity to engage in dialogue with students and to contribute to teaching. Interestingly, they also reported that they had found the experience cathartic, an aspect which needs to be considered carefully when planning a strategy to promote involvement.

Price (2004) also describes a project to involve clients in the classroom; in this case, parents of children with complex health needs. The action research study involved qualitative and quantitative evaluation by thirty five students and an observer. Responses indicated that the experience acted as a powerful stimulant to students, it gave a realistic view, encouraged theory and practice integration and presented issues in a memorable way. It is interesting to note that the parents' views were not explored in this study and that, as in the studies by Hanson and Mitchell (2001) and Costello and Horne (2001), the data focused on students' perceptions of their learning and did not attempt to evaluate any change in practice as a result of the intervention.

Barnes et al., (2000) report on the findings of a case study of the involvement of patients in the development, delivery and evaluation of an interprofessional, postgraduate mental health programme. The data comprise documentary analysis, peer interviews with nine patients, group interviews with twenty four students and a survey of twenty nine user groups. The authors conclude that data provided evidence that patients' knowledge was identified and used and of added value in terms of inter-professional working for partnership. However, they caution that although a partnership approach was used from the outset, university constraints impinged on power sharing and that it is important to acknowledge the differentials in power rather than demanding equality. Although this paper presents a small scale evaluation of a particular programme, the same authors later report the findings of a five year evaluation of the project (Barnes et al., 2006; Carpenter et al., 2006). This comprised participant observation, twenty three individual and eighteen group interviews with students and their managers and student ratings of knowledge pre- and post- programme. An interesting feature of this research is that clients also rated the quality of care provided by these students. Outcomes for clients were positive, but this was also reflected in the comparative group so no conclusions can be drawn in respect of the programme. However, student attitudes and behaviour were positively influenced in relation to partnership working and service user involvement in care. Although this is a small scale project, it is the only retrospective longitudinal evaluation identified in the literature and was conducted rigorously by the researchers. The papers reviewed in this section report mainly on small scale evaluations of patient and client involvement in teaching sessions which demonstrate a positive effect on learning but do not explore the impact of this learning on practice. The conclusions, therefore, need to be treated with caution, and account taken of the fact that involvement of individuals in teaching sessions may not be representative (Skidmore, 2005).

6. Structured Dialogue

Structured dialogue and reflection initiatives demonstrated a higher level of engagement than many of the other studies reviewed because they promote active discourse and equal responsibility between students, patients and clients. Although the papers report evaluations of small scale studies, they do provide examples of learning in the practice setting and provide evidence of perceived benefits in a range of cultures from Israel (Shor and Sykes, 2002), the United States (Scheyett and Diehl, 2004; Scheyett and Kim, 2004), and the United Kingdom (Elliott et al, 2005; McAndrew and Samociuk, 2003). It is interesting to note that these are recent studies and this may indicate a move to a more inclusive partnership approach.

A number of papers report on projects to involve clients in facilitated structured dialogue or reflective sessions with students. Scheyett and Kim (2004) used attitude questionnaires and interviews to evaluate a one-day structured dialogue session between ten social work students and ten mental health service clients in the United States. The data indicate that the facilitated dialogue sessions had a positive impact on students' attitudes and on their intentions to change practice, although they indicated some confusion about how to create healthy boundaries in professional work. Scheyett and Kim (2004) advise that educational partnerships improve students' listening skills and help them to develop empathy and respect and to recognise clients' expertise. Clients also identified benefits in terms of being valued, helping others and participating in the dialogue itself. Feedback from clients indicated that they found the structured dialogue sessions valid and empowering. Scheyett and Diehl (2004) report on the same process of facilitated dialogue and recommend that policies need to be developed to

enable client involvement in assessment and evaluation and to overcome barriers in relation to roles and responsibilities, confidentiality and consumer preparation. The researchers conclude that this approach has the potential to improve students' attitudes towards people with mental health problems and to challenge negative stereotypes and the researchers advocate the use of a partnership approach to acknowledge clients' knowledge and experience and to promote full engagement in teaching, assessment and curriculum committees and review. The structured dialogue approach had previously been reported by Shor and Sykes (2002) in Israel with similar positive conclusions. Shor and Sykes (2002) report on a one day structured dialogue session between social work students and mental health clients. Two thirds of students in the study felt that the structured dialogue sessions with people with mental illness had a positive impact and one response indicated that it had "opened their eyes to the person behind the illness" (p.67).

Both of the above studies relate specifically to social work programmes and mental health clients, but it is of interest that similar conclusions were reached in the United States and Israel. The differences in both policy and organisational culture need to be recognised when considering the relevance of these findings to programmes in the United Kingdom.

Elliott et al (2005) describe a less structured approach in terms of user conversations in the United Kingdom. They introduced conversations between fifty six social work students and thirty three clients to explore their perceptions of the characteristics of a good social worker and to contribute to student assessment. Evaluation by means of interviews with twenty six of the clients involved and questionnaires to students were positive. They report that this process reverses the usual power imbalance, with users

and carers acting as informal assessors and making judgements about students' interpersonal skills, values and assumptions. Although, again, this research is context specific, it provides data from a relatively large sample and uses a combination of interviews and questionnaires to provide a rigorous project evaluation.

McAndrew and Samociuk (2003) report on the evaluation of a project to develop a model of sustained patient involvement in mental health curricula. Reflective sessions were timetabled within placements and involved seven mental health nursing students, five patients, two lecturers and an observer. These sessions were audio-taped and transcribed to provide ongoing evaluation and pre- and post-test attitude questionnaires were used with students and service users. The data indicated that initially patients felt that they were in the dominant position offering neophyte nurses their expertise, whereas students were more collaborative in their approach. Students expressed concern about confidentiality, the need for safety within the group and not being held responsible for issues within the NHS.

Wikler (1979) describes one of the earliest reported examples of client involvement in the education of social work students. The project focused on parents of children with learning disabilities, who were involved in training and assessing students in interviewing skills. Although this project was not formally evaluated, it is interesting to note that the author identifies benefits in facilitating students to enhance their listening skills, a skill which is referred to regularly in subsequent literature. Ikkos (2003) also reports positive evaluation feedback from participants in a small scale project to involve patients in developing interview skills, although some issues were identified with individual contributions. This involved five patients who engaged alongside clinical tutors in workshops with thirty six doctors. Fisher et al. (2005) present the findings of a project in

which six patients receiving treatment for depression were trained in research and interviewing techniques and then acted as researchers to explore the effectiveness of treatment with twenty three other patients. An interesting conclusion from this research was that these patient-led interventions changed the behaviour of GPs and other primary health care professionals. These small scale, qualitative studies adopted a case study approach and findings again are context specific.

Humphreys (2005) involved clients in a consultation process with social work students to increase their understanding of discrimination and oppression and report that this was positively evaluated. Pierpont, Pozzuto and Powell (2001) report the findings of the evaluation of a small scale project, in the United States, in which eighteen post graduate students were encouraged to learn from their clients. They concluded that this project promoted students' learning about listening skills and the implications of policy on clients and that it demonstrated the integral nature of policy and practice. Bordelon (2003; 2006) describes a participatory learning project in which students work with a learning disability community action group to develop knowledge of their service needs and to improve their interpersonal and collaborative skills. Although the project is reported as effective in meeting its outcomes, no evaluative data is included.

The projects reviewed above all adopt a higher level of engagement than those reviewed in previous sections because they promote active dialogue and equal responsibility between students, patients and clients. Although the papers report evaluations of small scale studies, they do provide examples of learning in the practice setting and provide evidence of perceived benefits in a range of cultures from Israel, the United States and the United Kingdom.

7. Patient and Client Involvement in Assessment.

The studies which relate to patient and client involvement in the assessment of students relate to practice assessment and are largely informal in their approach. It is evident from these small scale studies that, despite the inherent issues and potential barriers, all stakeholders are in favour of this model of involvement in principle (Bailey, 2005; Elliot et al., 2005; Morgan and Sangarran, 1997; Speers, 2008). It is difficult to judge the level of partnership inherent in these projects, but it would seem essential to formally recognise the contribution of clients to student assessment if this is within a fully inclusive approach.

Formal recognition and Involvement of patients and clients in student assessment is less embedded in practice than in programme planning and involvement in teaching, but this is an area of growing interest (Kearney, 2003). A number of papers report on the involvement of clients in informal feedback on student practice (Cuming and Wilkins, 2000; Edwards, 2003; Elliott et al., 2005; Wikler, 1979) and several authors contend that this provides a valuable source of feedback for students and can empower participants (Cuming and Wilkins, 2000; Edwards and Miller, 2003; Jackson and Morrison, 1994; Parsloe and Swift, 1997). In addition, Elliott et al. (2005) argue that clients have a vital role in determining the characteristics of an effective social work student and they report their role in assessing the ‘user conversations’ referred to in the previous section.

However, there are currently few examples of involvement in the formal assessment of either academic or practice learning and Manthorpe (2000) warns that there may be inherent barriers to implementing this in HEIs due to rigid quality assurance mechanisms. It is interesting to note that Wikler (1979) reports that parents of children

with learning disabilities were actively involved in rating social work students' performance in the interview process almost thirty years ago. Advocacy in Action, Charles, Clarke and Evans (2006) involved clients in the assessment of social work students to determine fitness to practice and they report positive responses from those involved. However, these appear to have been obtained through informal discussions rather than formal evaluation processes.

Morgan and Sanggaran (1997) report a project which used feedback from mental health patients to facilitate student learning in clinical environments. Questionnaires were used to evaluate the impact of this feedback with a sample of forty three students and seventy four patients. Both groups endorsed patient participation in student learning and the researchers recommend that this approach is further developed in nurse education curricula. It is interesting to note that this research was undertaken ten years ago and little evidence has been found to indicate that this has been replicated in other organisations, despite its resonance with contemporary policy.

Edwards (2003) reports on a research study in which semi-structured interviews were used to consult the views of practice teachers about clients' involvement in social work education. The researcher acknowledges that the study is limited because "service user involvement is thus seen 'through the lens' of the practice teacher supervising the student" (p.343). This is a small scale study with eight respondents, selected by purposive sampling and an inductive, grounded theory approach was used to analyse data. The client was perceived to contribute to feedback on student performance but to have no responsibility for the assessment process. This raised a debate in terms of empowerment; an emergent theme was that client feedback needed to be taken seriously and not to be used in a tokenistic way.

Bailey (2005) used an action research approach to involving patients in the assessment of professional competence. This is related to a programme which has involved patients in its design, delivery and evaluation since it began in 1997 (Barnes et al., 2000). The project involved twenty seven self-selected patients and nine course participants. Qualitative data were gathered from focus group interviews and group discussions and a grounded theory approach was employed to formulate a conceptual framework of users' and participants' experiences. Bailey (2005) concludes that patients did provide detailed, constructive and meaningful feedback which clearly related to issues of importance from a user perspective.

Speers (2008) reports on a small scale research study which explored stakeholders' views of involving patients in the assessment of competency in student mental health nurses in the UK. Semi-structured individual interviews were conducted with five clients and focus groups with seven students, four ex-students, six mentors and two lecturers. The findings indicate differences in responses between the four groups although all were largely positive about the concept of patient involvement. Nurse participants expressed reservations about the implementation of the proposal in practice although were in favour in principle.

The studies which relate to patient and client involvement in the assessment of students focus on practice assessment and are largely informal in their approach. It is evident from these small scale studies that despite the inherent issues and potential barriers, all stakeholders are in favour of this model of involvement in principle. It is difficult to judge the level of partnership inherent in these projects, but it would seem essential to formally

recognise the contribution of patients and clients to student assessment if this is within a true partnership approach.

8. Stakeholder Perceptions

The majority of research studies identified in the literature search focused on stakeholder perceptions of patient and client involvement. These largely comprise qualitative studies, involving interviews and focus groups with patients, clients, students, practice teachers and lecturers. For example, participants in Khoo, McVicar and Brandon's study (2004) reported that they had implemented change following a programme which involved clients. Those in Hanson and Mitchell's (2001) study indicated that they had been involved in a range of client issues in practice. However, none of the research studies measured the outcomes of patient and client involvement in practice and the majority of conclusions were based on students' perceptions of their own learning.

Jackson and Morris (1994) used questionnaires and tape recorded discussions to explore students', lecturers' and practice teachers' perceptions of families and child protection in social work education. They reported that all seven social work programmes surveyed explored partnership in relation to child protection but that there was a lack of definition of the concept. Almost all respondents indicated that partnership working was integrated throughout the programme. Students also reported that race and language were covered in all programmes, but disability, sexuality, class, religion and culture had limited coverage. None of the seven programmes reviewed included a formal review process in relation to the teaching of partnership. The researchers concluded that partnership should be addressed explicitly to prevent it becoming lost or

diluted within the programme, they also recommend that programmes that link this teaching with practice experience are most effective. However, Felton and Stickley (2004) following interviews with five lecturers, identified several barriers to effective involvement, relating to the concepts of role and power relationships.

Khoo, McVicar and Brandon (2004) report the findings of one of the few retrospective studies which follow up students' perceptions of patient and client involvement once they are in practice roles. The data comprised twenty six questionnaires and ten telephone interviews with mental health practitioners who had previously completed a post-graduate programme in the UK. The majority (87%) reported that they had benefited personally and professionally from the involvement of patients in the programme and many had implemented change in practice as a result of this. It would be interesting to identify actual changes in practice rather than relying on students' perceptions of their own attitudes and performance.

As previously discussed, Taylor et al. (2006) used telephone interviews and focus groups to explore stakeholders' perceptions of partnership relationships in social work programmes. They identified numerous examples of partnerships in programme development and delivery, for example, involvement in teaching sessions and student interviews. Benefits for clients were reported to involve therapeutic value; that is, increased self-confidence, knowledge and skills and in some cases accreditation for their participation. However, there were few examples of comprehensive involvement in terms of delivering whole modules and student assessment or of taking responsibility for the design of learning and assessment. Educators expressed concern about the risks involved with what some termed a 'personal testimony' approach to learning. They also

described a number of practical difficulties which acted as barriers to involvement, for example, rigid timetables, finance issues and accessibility.

As in the previous sections, the research studies are context specific but do identify common themes across a range of programmes.

9. Consumer Academic Role

The ‘consumer academic’ and ‘service user academic’ initiatives demonstrate a commitment to a partnership approach which promotes true involvement in all aspects of education provision, with equality of roles (Happell and Roper, 2002; Happell, Pinikahana and Roper, 2003; Lathlean et al*.,* 2006). These papers report small scale projects within specific programmes, but provide examples of practice which is at the upper end of the continuum of involvement. Although these studies demonstrate a commitment to engaging in a true partnership approach, again there is no attempt to measure the impact on practice.

Several studies describe projects to introduce patients and clients as equal partners in the education of health and social care programmes, with roles described as ‘consumer academic’ and ‘service user academic’. Happell and Roper (2002) describe a case study approach with the development and implementation of a ‘consumer academic’ role, for mental health patients, to teach on a mental health nursing programme in Australia. The project was evaluated by means of pre- and post-course attitudinal questionnaires to the twenty five students (Happell, Pinikahana and Roper, 2003). The data demonstrate positive attitudes in respondents, in both phases of the survey,

towards consumer participation although this was increased post-course. This is a small convenience sample and the research is specific to one university in Australia and although this particular study does not explore the impact on practice it would be interesting to conduct further longitudinal research.

Lathlean et al. (2006) built on this work and introduced the role of 'service user academic' to lead the involvement agenda within a United Kingdom university. The researchers employed a process of 'democratic evaluation' in which the knowledge of all stakeholder groups were valued equally. Respondents included thirty five students, six service user academics and ten lecturers and data indicated that the post raised the esteem of the academic team, presented an optimistic model for students and provided a valuable knowledge source on the involvement agenda. However, there were concerns raised about the title of the post which some felt may be stigmatising. Whilst implementing this role, Lathlean et al. (2006) simultaneously established an external user and carer reference group and a co-operative enquiry of client and student participation. They conclude that the overall project promoted a culture of true participation, but advise that this requires organisational commitments to overcome that range of barriers which need to be overcome.

Simons et al. (2007) and Lathlean et al. (2006) evaluated the development of this 'service user academic' post. An observational case study approach was adopted and comprised purposive sampling to identify six members of a user and carer reference group, ten lecturers and thirty five students. The researchers conclude that the service user academic was a powerful role model for students and was an effective way to integrate service users' perspectives into the curriculum. However, they report that organisational factors inhibited the introduction of socially inclusive practices. These

initiatives demonstrate a commitment to a partnership approach which promotes true involvement in all aspects of education provision, with equality of roles. Although only small scale projects, these provide examples of practice which are at the upper end of the continuum of involvement. Although these studies demonstrate a commitment to engaging in a true partnership approach, again there is no attempt to measure the impact on practice.

10. Conclusion to Chapter

There is an increased emphasis in government policy on both patient and client involvement and on inter-professional service delivery (D.H., 2000a). The corresponding impact on professional education makes it imperative that education providers work with all stakeholders to develop effective systems for service user involvement to respond to these drivers (Taylor et al*.,* 2006). A large number of publications were accessed in relation to patient and client involvement in health and social care education. However, the majority of these were discussion based papers or small scale local evaluations of patient and client involvement in education programmes (for example, Ager et al., 2005; Barnes et al., 2006; Costello and Horne, 2001; Elliot et al., 2005; Lathlean et al., 2006' Scheyett and Diehl, 2004). Although these evaluation studies all reported positive effects on learning, none explored the impact of this learning on practice. Twenty six empirical research studies were identified from the numerous papers reviewed (these are summarised in appendix 1 of the thesis). However, these studies are generally not outcome focused and many lack the necessary rigour to judge whether partnership working with patients and clients makes a difference.

There is a longer history of involvement in relation to this in social work and mental health education, than other health programmes, although this review indicates that all areas are now embracing this. It is evident from the surveys which described current practice in the United Kingdom, that there is a range of approaches to patient and client involvement, and that these are still largely at the lower end of the partnership continuums discussed earlier. This literature review has demonstrated that there is extensive support for the involvement of patients and clients in health and social care education, although it is evident that there is currently a lack of consistency in this involvement (Ager et al., 2005; Levin, 2004; Molyneux and Irvine, 2004, Taylor et al., 2006; Warne and McAndrew, 2005;).

The majority of partnership work described in the literature in relation to patient and client involvement in health and social care is at the lower end of these continuums and includes consultation and curriculum involvement. Several recent initiatives, for example structured dialogue (Scheyett and Diehl, 2004) and the service user academic role (Lathlean et al., 2006), demonstrate commitment to involvement in all aspects of education provision, with equality of roles. Although these studies demonstrate commitment to engaging in a true partnership approach, there is no attempt to measure the impact on practice. These projects provide examples of practice which are at the upper end of the continuum of involvement, but it would be inappropriate to attempt to transfer the findings of these studies to the context of this thesis.

Partnership working is consistent with the government approach to consultation inherent in contemporary health and social care policy developments in the UK. However, despite the extensive rhetoric indicating a paradigm shift, in reality there may be competing demands between education and practice cultures (Warne and MacAndrew,

2005). It was interesting to note that a large number of papers included in this chapter were published in the past five years. This provides evidence that patient and client involvement in health and social care education is an area of increasing importance. This is appropriate to this research study which is intended to add to the increasing body of knowledge in this field

The majority of publications comprise discussion papers or examples of small scale, context specific projects, which individually would not provide evidence for education practice. A number of claims are made in the literature in respect of the benefits to students of patient and client involvement in professional education. These include development of fitness to practice in terms of: knowledge base; values; attitudes; intentions; ability to reflect; increased understanding of patients' and clients' expertise; and reduced stereotyping and stigmatisation. The research reported by Barnes et al. (2006) and Carpenter et al. (2006) did include patients' and clients' ratings of quality of care, but did not identify significant differences due to their involvement in the education programme. Students in Hanson and Mitchell's (2001) research perceived that their programme facilitated them to engage in a range of user initiatives in practice. Overall there is limited research evidence that these perceived benefits have a positive impact on health and social care practice.

Although the value of practice based learning and assessment is recognised, and has recently been strengthened in nursing, midwifery and social work programmes, there is little evidence that patient and client involvement is formalised in practice settings. There is an assumption that students learn about partnership work in practice but this is not formalised or evaluated and some educators reported that the culture of some organisations may detract from this. The studies focusing on structured dialogue,

reflection and informal assessment are the only studies which address learning from patients and clients in practice settings. This is surprising in the context of an increased emphasis on practice based learning in pre-qualifying programmes. It is also interesting to note that, despite the policy drivers to promote inter-professional working and learning, only one of the studies reports client involvement in inter-professional programmes (Barnes et al*.,* 2006; Carpenter et al*,* 2006).

The emphasis on public involvement in all aspects of health and social care has major implications for health and social care education programmes, which should be patient focused. The publications reviewed in this chapter suggest that professional education programmes should adopt a holistic approach to learning, which includes and values learning from patients and clients. A number of recent publications advocate complexity theory as a framework to underpin this holistic learning. For example, Griffiths (2002) advises that complexity theory provides a framework to understand and value the knowledge gained from a specific patient, in a specific context. This is supported by Sweeney (2006), who applies complexity theory to knowledge acquisition in general practice and argues that knowledge should incorporate the concept of personal significance. As in the previous two chapters, this supported the researcher's intention to further explore complexity theory and to include this as a specific research question within this study.

Although there is a plethora of literature relating to learning from patients and clients, the papers reviewed in this chapter reported mainly on small scale evaluations. These demonstrate a positive effect on learning in classroom settings, but do not explore the impact of this learning on practice. The value of practice based learning and assessment is recognised, but there is little evidence in relation to strategies used to

promote this learning or to the underpinning educational theory (Speers, 2007; Taylor et al., 2006). This led to the development of specific research questions based on the conclusions of this chapter:

- What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements?

- What teaching and learning strategies are used to promote learning from patients and clients in practice settings?

- How relevant are contemporary theories to the phenomenon of learning from patients and clients in practice settings?

- How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

The first three chapters of this thesis have provided a comprehensive review of the literature relating to the context of this research study. It is evident that there are few studies which directly address learning from patients and clients in practice settings. The aim of this research study is, therefore, to explore pre-qualifying, nursing, midwifery and social work students' perceptions of learning from patients and clients in their practice placements. Table 2 below demonstrates the development of specific research questions from the findings of the literature reviews. These will be discussed in the following chapters in relation to the research approach and design and methods of the study.

Table 2: Table to Demonstrate the Development of Research Questions from the Conclusions of the Literature Reviewed.

Literature Reviewed	Conclusions from the Literature	Research Questions
Chapter 1: **Professional education in health and social care: policy drivers and theoretical basis**	Extensive government and professional policies - increased emphasis on the practice elements of professional programmes with a diverse range of placement experiences. Andragogical, social learning, experiential, reflective and transformational learning theories were considered applicable to the context of this study. Potential tensions were identified within programmes - competing agendas of professional competence and student empowerment. Health and social care organisations may be considered as complex adaptive systems - complexity may, therefore, provide a complimentary perspective for professional education.	How relevant are contemporary learning theories to the phenomenon of learning from patients and clients in practice settings? How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?
Chapter 2: **Learning in practice settings**	Plethora of literature but does not focus specifically on learning from patients and clients in practice settings. Comprises small scale, qualitative studies, focusing mainly on nursing programmes - the findings are context specific and cannot, therefore, be generalised. It is evident from the literature that a range of individuals are involved in facilitating student learning for, in and from practice experience, including lecturers, practice teachers, mentors and other members of the practice team. Focus on networks, relationships and connectedness.	What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements? What teaching and learning strategies are used to promote learning from patients and clients in practice settings? How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

Table 2: Table to Demonstrate the Development of Research Questions from the Conclusions of the Literature Reviewed.

Literature Reviewed	Conclusions from the Literature	Research Questions
Chapter 3: **Learning from patients and clients**	Plethora of literature but does not focus specifically on learning from patients and clients in practice settings. The papers reviewed in this chapter reported mainly on small scale evaluations of patient and client involvement which demonstrate a positive effect on learning but do not explore the impact of this learning on practice. The majority of partnership work described in the literature, in relation to patient and client involvement in health and social care, is at the lower end of these continuums and includes consultation and curriculum involvement. Although the value of practice based learning and assessment is recognised there is little evidence that patient and client involvement is formalised in practice settings. Partnership working with patients and clients is essential in health and social care service and education. This indicates the need for a holistic approach which values alternative forms of knowledge.	What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements? What teaching and learning strategies are used to promote learning from patients and clients in practice settings? How relevant are contemporary theories to the phenomenon of learning from patients and clients in practice settings? How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

Chapter 4: Philosophical and Methodological Considerations

1. Introduction to Chapter

This is the first of two chapters which address the methodology of the research enquiry. The first chapter will outline the philosophical and conceptual approaches to the research, and the second will then describe the design and methods adopted. The two chapters are inextricably linked. This chapter will concentrate on the philosophy and science underpinning the method, and the following chapter will highlight the ways in which this influenced the design and methods of the enquiry.

This chapter will commence with clarification of the research aim and research questions in the light of the literature reviewed in the previous chapters. The choice of research approach will then be justified, in respect of the range of paradigms and research approaches considered and their relevance to the focus of the enquiry. The paradigms considered include positivism, post-positivism, critical theory, and constructivism. The decision making process will be articulated below, in relation to the ontological, epistemological and methodological stances of these paradigms and their congruence with those of this thesis. The research criteria associated with each paradigm will also be identified and will be applied to issues relating to this specific study. It is evident that critical theory and constructivism are the paradigms most congruent with this research aim, because of their focus on understanding individual constructions of experience and of the relationship between the researcher and the respondents. It is also apparent that qualitative research approaches are the most appropriate. This chapter, therefore,

explores the major qualitative research methodologies of ethnography, grounded theory, and phenomenology, in relation to this investigation.

The chapter presents an argument that phenomenology is the most appropriate approach to explore meanings, in this case the meaning of learning from patients and clients, in respondents' own terms. The discussion will then continue with a critical review of the two major strands of phenomenology as applied to research; that is, descriptive and existential phenomenology. Both approaches were considered relevant to the nature of the enquiry but this chapter concludes that the philosophy of descriptive phenomenology, proposed by Husserl (1859-1938), is most appropriate to explore the phenomenon of learning from patients and clients in practice settings, both as an underpinning philosophy and as a research approach. The following chapter will then focus on the specific approach selected for this study; that is, the descriptive phenomenological approach of Amedeo Giorgi (1931-).

2. Clarification of Research Aim and Questions

Chapter one included a review of contemporary health and social care policies and discussed their implications for education programmes leading to professional qualification. It was suggested that there are potential tensions between outcome driven curricula, which have to conform to rigid professional standards, and the need for professionals to respond effectively to the constantly changing environments of health and social care. A major focus of the modernisation process is the emphasis on public involvement in all aspects of health and social care, which has also led to increased involvement in all aspects of curriculum design and delivery. The critical evaluation of a

range of contemporary learning theories, presented in chapter one, concluded that these are relevant to professional education within the context of this thesis. Complexity theory was also reviewed and was found to be appropriate to contemporary health and social care. The concept of complex adaptive systems was considered to be applicable to the practice organisations in which pre-qualifying students complete parts of their programmes. It was also suggested that complexity theory is relevant to professional education programmes because of its focus on uncertainty and unpredictability, networks, relationships, holism, personal knowledge, simultaneity and distributed control.

Chapter two demonstrated that practice learning is central to professional education. It identified the need for collaborative approaches between universities and service organisations to understand their complex natures and to promote effective interpersonal relations. This supported further consideration of complexity theory within this thesis. It is evident from the literature that a range of individuals are involved in facilitating student learning for, in, and from practice experience, including lecturers, practice teachers, mentors and other members of the practice team. The literature identifies a limited role in respect of the lecturer role in promoting learning in practice. Mentors (for nursing and midwifery students) and practice teachers (for social work students) are consistently reported in the literature as having the most influential role in student learning and assessment in practice.

The literature reviewed in chapter three demonstrated a lack of empirical evidence to support the involvement of patients and clients in nursing, midwifery and social work education. A range of recently published, context specific, small scale studies were identified, but many of these lacked the necessary rigour to judge whether partnership working with patients and clients had an impact on practice. However, the published

literature does add to the growing body of knowledge in this area; it demonstrates widespread support for the involvement of patients and clients in professional education programmes, whilst raising several issues which need to addressed. It is apparent that there is currently no clear definition of partnership and the studies reviewed demonstrated a range of approaches, largely at the lower end of the continuum of engagement. The role of patients and clients is unclear and needs to be clarified in order to address potential power imbalances in relationships, and there may be conflict between professional and patients'/clients' perspectives.

This chapter will continue with a justification of the research approach, descriptive phenomenology, which was used to explore students' perceptions of learning from patients and clients in practice settings, in order to articulate this tacit knowledge.

Following the literature review, the research aim was revised. It was originally intended:

- to explore and model the processes involved when students learn from patients and clients during practice placements.

The aspect of tacit knowledge raised in the literature was discussed with respected academic colleagues and PhD supervisors and the focus of the research was modified accordingly. The final aim of the research was then agreed:

- to explore pre-qualifying, nursing, midwifery and social work students' perceptions of learning from patients and clients in their practice placements.

The change in focus of the research aim - from exploring processes to exploring meaning and perception - was an important consideration in determining the paradigm underpinning this thesis and the design and methods adopted. This decision making

process will be further articulated below, in relation to the ontological, epistemological and methodological issues within the paradigms of positivism, post-positivism, critical realism and constructivism.

Although it was not the intention to undertake structured interviews, or to lead the participants to answer specific questions, it was anticipated that the research enquiry would address the following broad questions:

- What are pre-qualifying, nursing, midwifery and social work students' experiences of learning from patients and clients in practice placements?
- What teaching and learning strategies are used to promote learning from patients and clients in practice settings?

Following the review of policies, theories and literature in the first part of this thesis two further research questions were proposed:

- How relevant are contemporary learning theories to the phenomenon of learning from patients and clients in practice settings?
- How relevant is complexity theory to the phenomenon of learning from patients and clients in practice settings?

3. Research Paradigms

To ensure rigour within qualitative studies, it is important that the researcher explicitly describes the decision-making trail within the report to enable auditability by readers (Annells, 1999; Koch, 1994; Maggs-Rapport, 2001). The following definition was used

to inform decision making in terms of the most appropriate paradigm to underpin this thesis: “A paradigm may be viewed as a set of *basic beliefs* (or metaphysics) that deals with ultimates or first principles. It represents a *worldview* that defines, for its holder, the nature of the ‘world’ “ (Guba and Lincoln, 1994, p.107). Clear consideration of the philosophical basis of research is essential to ensure congruency of the study design in terms of the: “inter-relationship relationship between the ontological (nature of reality), epistemological (what can be known) and methodological (how it can be known) levels of enquiry” (Proctor, 1998, p.74). To facilitate the researcher in this process, the following questions were used to inform decision-making:

1. “The ontological question: What is the form and nature of reality and, therefore, what is there that can be known about it?
2. The epistemological question: What is the relationship between the knower or would-be knower and what can be known?
3. The methodological question: How can the inquirer (would-be knower) go about finding out whatever he or she believes is known?”

(Guba and Lincoln, 1994, p.108).

The alternative inquiry paradigms of positivism, post-positivism, critical theory and constructivism were explored in relation to the ontological, epistemological and methodological stance of this thesis. These are summarised in Table 3 below and will now be discussed to provide evidence of the decision-making process undertaken by the researcher.

Table 3: Application of Paradigms to Thesis in Terms of Ontology, Epistemology and Methodology to the Thesis

Question	Positivism	Post-positivism	Critical Theory	Constructivism	Thesis
Ontology	Naïve realism Apprehendable reality Reductionist and deterministic Research can identify the true state of affairs	Critical realism Imperfect apprehension of reality Reductionist and deterministic Research can identify truth as closely as possible	Historical realism Reality shaped by political, cultural, social, ethnic and gender factors over time	Relativism Realities understood as multiple mental constructions Socially and experientially based Local and specific in nature	Reality is presented by each subject based on his/her experience.
Epistemology	Constrained by ontology i.e. relationship must be objective Dualist – researcher and subject are independent entities Not influenced by values and beliefs.	Modified dualist/objectivist Objectivity is an ideal aim Critical community used as external guardians of objectivity	Transactional/subjectivist Researcher and subject are interactively linked Values of researcher influence inquiry Findings are value mediated	Transactional/subjectivist Researcher and subject are interactively linked Findings are created as the research proceeds	Interactive relationship between researcher and subject. Researcher 'brackets' values and beliefs.
Methodology	Experimental/manipulative Questions and/or hypotheses are subjected to empirical testing. Control of variables. Quantitative methods	Modified experimental/manipulative Falsifying (rather than verifying) hypotheses Natural settings – situational information May include qualitative methods	Dialogic/dialectical	Hermeneutical/dialectical	Phenomenology. In depth interviews/ conversations.

(adapted from Guba and Lincoln, 1994, p.109)

3.1 Positivism

Positivism is the paradigm that has dominated the physical and social sciences for over four hundred years and is still considered by many scientists as the gold standard within health research, particularly with the influence of medical research (Denzin and Lincoln, 1994). The ontological basis of positivism assumes a naïve realism and a reality which is apprehendable and that research can identify the true state of affairs: “An apprehendable reality is assumed to exist, driven by immutable natural laws and mechanisms” (Guba and Lincoln, 1994, p.109). Positivism is reductionist and deterministic in nature, in that it aims to identify cause and effect and to make predictions (Cohen and Manion, 1994). In the positivist paradigm the epistemological basis is constrained by the ontology; that is, the relationship between the researcher and participants must be objective. The researcher adopts a distant, non-interactive relationship, with aims to exclude bias and personal values.

Research methodology appropriate to the positivist paradigm is experimental and manipulative in nature. It involves the formulation of questions and/or hypotheses, which are subjected to empirical testing, whilst exerting maximum control of variables. This relies on quantitative approaches to research, typically experiments which exert careful control and aim to make predictions. It is evident from Table 3 that neither the epistemological or ontological basis of positivism are consistent with the focus of this thesis. It is also apparent that the methodologies associated with positivism; that is experimental and manipulative approaches, would not address the aim of this research enquiry. It is the researcher’s intention to present reality as it is presented by each

respondent, based on individual experience, and to achieve this by means of an interactive relationship with each respondent.

3.2 Post-positivism

Post-positivism has been developed over the past few decades in response to criticisms of positivism (Denzin and Lincoln, 1994). However, post-positivism remains essentially within the same set of essential beliefs about the nature of reality. Post-positivism involves research in natural settings, incorporating situational information and accepting discovery as an element of inquiry. Post-positivism has an ontological basis of critical realism; reality is assumed to exist, but it is imperfectly understandable because of the complexity of human nature. The epistemological basis is of modified dualist/objectivist stance, which views objectivity as the regulatory ideal (Guba and Lincoln, 1994). This epistemological basis of the post-positivist paradigm assumes that the relationship between the researcher and the subject is that of modified dualist/objectivist, with objectivity as an ideal aim. The critical community are used as external guardians of objectivity.

The post-positivist paradigm involves modified experimental and manipulative approaches: “Emphasis is placed on “critical multiplism” (a refurbished version of triangulation) as a way of falsifying (rather than verifying) hypotheses” (Guba and Lincoln, 1994, p.110). Post-positivist methodologies can include qualitative approaches appropriate to the research aim. However, as with the paradigm of positivism above, it is evident that the ontological and epistemological bases of post-positivism are not

consistent with either the researcher's philosophical stance or the requirements of this enquiry.

3.3 Critical Theory

The ontological basis of the critical theory paradigm assumes historical realism; that is, that reality is shaped by political, cultural, social, ethnic and gender factors over time. Critical theory was developed in Frankfurt, Germany, in the 1920s and encompasses a set of alternative paradigms, including neo Marxism, feminism, materialism and participative enquiry (Kincheloe and McLaren, 1994). The epistemological basis of the critical theory paradigm assumes a transactional and subjectivist relationship between the researcher and the subject, who are interactively linked. This paradigm of inquiry accepts that the values of the researcher influence the research process and that the findings are value mediated.

In the critical theory paradigm, the boundaries between the ontological and epistemological questions are blurred and the two are inextricably linked with the relationship between the individual researcher and individual participant. The methodology associated with critical theory requires a dialogue between the researcher and the participants, for example ethnographic approaches. This dialogue should be dialectical in nature to: "transform ignorance and misapprehension (accepting historically mediated structures as immutable) into more informed consciousness (seeing how the structures might be changed and comprehending the actions required to effect change" (Guba and Lincoln, 1994, p.110).

The critical theory paradigm was considered to be relevant to this enquiry. The ontological stance would incorporate the political, social, ethnic and gender factors impacting on learning from patients and clients in practice settings. Critical theory also recognises the subjective nature of the phenomenon under investigation and the relationship between the researcher and the participants, which are directly relevant to this enquiry.

3.4 Constructivism

The term constructivism represents an alternative paradigm with a major difference in assumption to positivism and post-positivism; that is, a move from ontological realism to ontological relativism.

> Realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures) and dependent for their form and content on the individual persons or groups holding the constructions.
>
> (Guba and Lincoln, 1994, p.111).

The ontological basis of constructivism is that multiple realities exist, which are interpreted, by individuals, in time and place. Reality is, therefore, relative and is constructed from the mental constructions of individuals and reconstructed through communication and interpretation (Strauss and Corbin, 1994). This is directly relevant to this enquiry, which aims to explore the meaning of experiences in respondents' own terms. The epistemological perspective within constructivism is that the researcher and

respondent identify the knowledge by means of their dialogue and it, therefore, requires hermeneutical/dialectical research approaches. This is also relevant to this enquiry, because, as with critical reality, it recognises the subjective nature of the phenomenon under investigation and the relationship between the researcher and the participants. .

Methodologically, constructivism aims to obtain individual reconstructions, to interpret these and to coalesce them into a consensus (Guba and Lincoln, 1994). This involves qualitative approaches, commonly adopting hermeneutical and dialectical methods to compare and contrast participants' descriptions of experience, beliefs and values, to achieve consensus (Guba, 1990).

3.5 Application of Paradigms to Research Enquiry

The previous sections considered the paradigms of positivism, post-positivism, critical theory, and constructivism, in relation to the aim of this research study. The philosophical basis of this study was considered in relation to the context of student nurses, midwives and social workers learning in practice settings and the overall aim of this thesis, which is to explore the meanings of experiences from the respondents' own perspectives. Guba and Lincoln (1994) contend that, with the exception of positivism, these paradigms are still in their formative stages and, therefore, there are no agreed definitions, meanings or implications. The beliefs, therefore, however well they are argued by their proponents, cannot be proved or disproved and must be taken on faith when accepting a particular paradigm.

The critical evaluation of the paradigms concluded that positivism and post-positivism were not relevant to this thesis because of their focus on objectivity and on prediction and control. However, critical theory and constructivism were consistent with both the findings of the literature reviewed in earlier chapters and the researcher's own belief that the context of this enquiry is subjectively perceived and socially constructed.

These research paradigms influence the research enquiry, in that paradigms informing enquiry define the terms of reference and identify what falls within or outside the boundaries of legitimate inquiry. This includes the issues of the enquiry aim, the nature and accumulation of knowledge, values, ethics, presentation of voice, training and quality criteria (Guba and Lincoln, 1994). Table 4 below demonstrates that the research criteria associated with both the critical theory and constructivist paradigms are consistent with the aim of this enquiry - to explore students' perceptions of learning from patients and clients - and with the researcher's own stance in relation to values, ethics and presentation of the respondents' voice. However, consideration of the nature of knowledge and of knowledge accumulation are more consistent with the constructivist paradigm, because of the focus on individual experience, which relies on respondents' own descriptions of those experiences, as lived, rather than on structural and historical perspectives. Methodologies associated with both critical theory and constructivism lend themselves to qualitative approaches. The training and quality criteria associated with these are familiar to both the researcher and her supervisors and are, therefore, appropriate to this study.

Table 4: Application of Paradigms to Thesis in Terms of Research Criteria

Issue	Post-positivism	Critical Theory	Constructivism	Thesis
Enquiry aim	Explanation Predication and control	Critique and transformation Restitution and emancipation	Understanding Reconstruction	Explore students perceptions of learning from patients and clients
Nature of knowledge	Non falsified hypotheses Probable facts or laws	Structural/historical insights	Individual reconstructions coalescing around consensus	Individual construction or reconstructions. May or may not be consensus.
Knowledge accumulation	Building blocks add to knowledge base Generalisations Cause and effect	Historical revisions Generalisation by similarity	More informed and sophisticated reconstructions Vicarious experience	Does not aim for generalisations. Describes situated structures of learning. Aims to identify essence of phenomenon.
Values	Excluded	Included – formative	Included – formative	Bracketing of researcher's values. Subjects' values included – formative.
Ethics	Extrinsic to research Policed externally	Intrinsic – revelation and fully informed consent	Intrinsic – revelation and fully informed consent	Intrinsic – revelation and fully informed consent.
Voice	Disinterested scientist	Transformative intellectual – advocate and activist	Passionate participant – facilitator of multi-voice Reconstruction	Researcher presents subject's own voice as presented by subject him/herself.
Quality criteria	Conventional rigour Internal and external validity Reliability and objectivity	Extent to which study addresses historical situatedness, erosion of ignorance, stimulus to action	Trustworthiness and authenticity	Trustworthiness and authenticity.
Training	Technical Quantitative and qualitative methods	Qualitative Dialogic/dialectical methods	Qualitative Hermeneutical/dialectical methods	Qualitative Hermeneutical/dialectical methods.

(Adapted from Guba and Lincoln, 1994, p. 112)

This chapter will continue with a review of the quantitative and qualitative approaches to research and will justify the decision to adopt a qualitative approach for this enquiry. It will then explore the potential qualitative methodologies of ethnography, grounded theory and phenomenology, in relation to this enquiry, in order to justify the research approach adopted.

4. Qualitative Research

As discussed above, the paradigms of positivism and post-positivism, which rely on quantitative research methodologies, were not considered relevant to this enquiry. This conclusion will be confirmed by the following discussion, which demonstrates that qualitative approaches are most closely aligned to this thesis.

The quantitative approach to research is described as being scientific. It strives for generalisability and the formation of theories, explaining the relationships between phenomena (Polit and Hungler,1995). This approach facilitates the collection and analysis of data in numerical form and usually involves large scale studies with representative samples (Blaxter, Hughes and Tight,1996). In contrast, the qualitative approach involves less researcher-imposed control and tends to emphasise the dynamic, holistic and individual aspects of human experience (Polit and Hungler,1995). This approach does not usually involve the collection of numerical data (Blaxter *et al.*,1996). The philosophical underpinnings of the two approaches are very different. Quantitative research is based on the logical positivist stance and is largely predictive; according to this approach, the truth can be completely represented and natural phenomena are regular and orderly (Denzin and Lincoln,1994).

This quantitative approach follows rigorous procedures and is used to examine cause and effect relationships, using a deductive process (Burns and Grove, 2003; Cohen and Manion,1994). Findings can, therefore, be used to provide explanations and predictions which can be generalised to other populations. Bradshaw (1997) argues that nurse education should adopt this rigorous, scientific approach to provide objective data to evaluate education programmes. However, in contrast, Cooper and Geyer (2008) suggest that, although health and educational research has traditionally adopted a reductionist stance, this may be dehumanising and does not provide a full understanding of the phenomenon.

Qualitative research is based on different assumptions. It encompasses a wide range of methodologies and is underpinned by multiple theoretical paradigms. Denzin and Lincoln (1994) argue that qualitative research emphasises processes and meanings, as opposed to measurement, stressing the socially constructed nature of reality and the relationship between the researcher and what is being studied. As previously discussed, health and social care education is underpinned by humanistic philosophies (Purdy, 1997a), which are consistent with qualitative research approaches. Qualitative research methodologies are widely advocated within the social sciences and these include a wide range of philosophies, approaches and research methods (Cohen and Manion, 1994; . and Lincoln, 1994; Mason, 1996). The close relationship between subject and researcher in qualitative research may be seen as an advantage, encouraging honest responses and increasing the external validity of the findings. On the other hand, the researcher's subjectivity may introduce bias, which may distort the data and the lack of standardisation of qualitative research may reduce its reliability (Carr, 1994).

To summarise the above discussion, qualitative research approaches, unlike quantitative approaches, explore human behaviour and actions and the researcher uses a range of techniques to record experiences. Whereas quantitative research approaches aim to identify causal relationships and to make predictions, qualitative research aims to describe or explain participants' thoughts and to understand complex phenomenon (Cohen and Manion, 1994; Polit and Hungler, 1995). It is evident, therefore, that qualitative approaches are the most appropriate to the context and aim of this study, which require the description of students' experiences of learning from patients and clients.

As previously stated, there is a range of distinct research approaches associated with qualitative research. Ethnography, grounded theory and phenomenology are examples of qualitative research approaches which are exploratory in nature and these were, therefore, considered in relation to this study. These are summarised and applied to the requirements of this research enquiry in Table 5 and are discussed below in relation to the research focus, participants, data collection methods, ontological and epistemological perspectives, and the types of results obtained (Janesick, 1994).

Table 5: Comparison of Ethnography, Grounded Theory and Phenomenology in Relation to Thesis (Adapted from Janesick, 1994, p.225).

Strategy	Research Focus	Participants	Data Collection Methods	Ontological Perspective	Epistemological Perspective	Type of Results
Ethnography	Explore student learning from interactions with patients and clients in practice context	Students with relevant experience	Participant observation Interviews	Historical realism Reality shaped by political, cultural, social, ethnic and gender factors over time	Transactional/subjectivist Researcher and subject are interactively linked Values of researcher influence enquiry Findings are value mediated	Description of day to day interactions between students and patients/clients
Grounded theory	Develop theory to explain learning from patients and clients	Students with relevant experience	Interviews Observation	Critical realism Imperfect apprehension of reality Reductionist and deterministic Research can identify truth as closely as possible	Modified dualist/objectivist Objectivity is an ideal aim Critical community used as external guardians of objectivity	Descriptions of processes involved in learning from interactions between students and patients/clients
Phenomenology	Describe the meaning of learning from patients and clients as expressed by students	Students with relevant experience	In-depth, conversational interviews	Relativism Realities understood as multiple mental constructions Socially and experientially based Local and specific in nature	Transactional/ subjectivist Researcher and subject are interactively linked Findings are created as the research proceeds	Descriptions of meaning of learning, in students' terms, from interactions between students and patients/clients

4.1 Ethnography

Ethnography has its origins in social anthropology and has been widely used in the social sciences in recent years; it has been described as both theory generating and as a holistic approach to data collection (Polit and Hungler, 1995). Ethnography emphasises the relationship between the participants and their natural environment and the researcher is required to spend time immersed 'in the field', in the world of the participants. This participant observation means that the researcher becomes the instrument of the research and enables him/her to identify the beliefs and values of the participants and to contextualise social action. This, in conjunction with open, in-depth interviews, leads to the development of frames of understanding which can be applied to a range of situations and to develop complex systems of meaning based on the participants' world (Atkinson and Hammersely, 1994).

Ethnography was considered relevant to the aim of this research study, to the extent that it would provide the opportunity for the researcher to become immersed in the practice experience of the students and to observe their interactions with patients and clients. However, the priority of the research was to explore the experiences which students identified as having an impact on them, rather than the routine interactions in daily practice. It was also possible that the presence of the researcher, as a participant observer, would have impacted on the nature of the relationships between students, patients/clients and professionals in the practice environment. As identified in the discussion of complexity theory in chapter one, the introduction of another agent (the researcher) to an already complex network within the practice areas would have changed the conditions in which these interactions occurred. Despite the many attractions of ethnography, on reflection, the ontological and epistemological

perspectives and the nature of results were not congruent with this enquiry and, therefore, ethnography was not adopted as the research approach within this thesis. However, it is important to note that whilst this thesis does not explore the cultural aspects of practice learning, it is recognised that this is an important issue, which would lend itself to an ethnographic enquiry.

4.2 Grounded Theory

Grounded theory emerged from the generation of theory from the data of social research (Glaser and Strauss, 1967) and, therefore, has a sociological perspective. Grounded theory was originally employed by sociologists and later by psychologists and anthropologists, but has become increasingly popular with practice professions including education, social work and nursing (Strauss and Corbin, 1994). A central feature of grounded theory is that it comprises constant comparative analysis; that is, data collection and analysis occur simultaneously and each item of data is compared with other data (Glaser and Strauss, 1967). The approach can combine qualitative and quantitative techniques for data collection and analysis (Strauss and Corbin, 1994). Strauss and Corbin (1994) contend that if a similar set of conditions exists and the same theoretical perspective, method of data collection and of data analysis are used, then two researchers should be able to reproduce the same theoretical explanation of a given phenomenon when using a grounded theory approach.

The emphasis of grounded theory is on theories and tentative hypotheses emerging from the raw data and then being verified, refuted or modified in the light of further data collection. This is distinguished from the hypothetico-deductive approach, which gathers

data to confirm or refute predetermined hypotheses. In this sense grounded theory is inductive in approach. The theory evolves during the research, by the continuous interplay between analysis and data collection, which is referred to as constant comparative analysis (Glaser and Strauss, 1967). Original theory may be generated from the data or existing theories may be elaborated and modified as incoming data is analysed; relevant research findings from previous studies can also be incorporated into the theory (Strauss and Corbin, 1994). Hence, grounded theory ensures that this theorising will not just be grounded in the data but will also draw upon relevant theories and models from the literature. The theory developed is tested in order to support or disprove the hypotheses generated.

Grounded theory was considered appropriate for the original research aim, which was process orientated (Morse, 1994), with the intention to explore and model the processes involved in student learning. This would involve the analysis of nursing, cognitive psychology, and other related literature in relation to the data obtained. If relevant theories were extrapolated from the literature, these would be further elaborated and modified throughout the research project. The theory developed would then be tested in order to support or disprove the hypotheses generated.

However, as discussed earlier in this chapter, the research aim was changed, following the literature review, because this identified that there is currently a lack of empirical evidence relating to learning from patients and clients in practice settings. It was deemed appropriate, therefore, to conduct an exploratory enquiry, which focuses on the meaning of experiences of learning in students' own terms. As evidenced in Table 5, grounded theory is not consistent with this revised research aim.

4.3 Phenomenology

Table 5, presented earlier in this chapter, demonstrates that phenomenology is consistent with the focus of this enquiry in terms of describing the meaning of learning from patients and clients and with the type of results which would provide descriptions of the meaning of these experiences in students' terms. Phenomenology was also considered to be appropriate in respect of its ontological perspective, which proposes that realities are understood as multiple mental constructions, are socially and experientially based and are local and specific in nature. The epistemological perspective, which is subjectivist and considers that the researcher and subject are interactively linked, with the findings created as the research proceeds, is consistent with the researcher's own philosophical stance and with that underpinning this thesis.

The researcher has presented the decision trail in relation to research paradigms, the choice of qualitative methodologies and the adoption of a phenomenological approach. Phenomenology will now be explored in greater detail and the alternative descriptive and existential perspectives will be considered, to justify the final decision to use descriptive phenomenology as the research methodology for this study.

5. Phenomenology as the Research Approach Influencing this Thesis

The method adopted should be appropriate to the research question and should be consistent with the researcher's own philosophy (Bell,1993). As discussed above, phenomenology was, therefore, chosen because of its relevance to both the research aim and to the researcher's own philosophy. Previous research experience and

discussion with supervisors confirmed that phenomenology was the most appropriate methodology to underpin this study because it is consistent with the desire to explore meanings (Guba and Lincoln, 1994). It is evident that this leads to a subjective approach to research, with the researcher facilitating the respondents to construct and express their own realities in relation to the research focus.

This chapter will continue with an in-depth review of phenomenology as a research approach. A number of philosophers further developed Husserl's original phenomenological philosophy and there is a range of associated research approaches. It is evident that two distinct research approaches developed, the descriptive phenomenology of Edmund Husserl (1859-1938) and the existential approach of his follower Martin Heidegger (1889-1976). Phenomenology became a significant movement in the twentieth century, with the contributions of other philosophers, who presented different approaches to phenomenology. However, all agreed that the focus of philosophy has to be consciousness and the nature of being; that is, a major shift from empiricism, which focuses on the things and nature, to phenomenology, which focuses on human beings and their worlds (Giorgi, 2006). This chapter will provide an overview of the descriptive and existential approaches to phenomenology and will explore the research approaches and methods proposed by contemporary philosophers in relation to the descriptive approach (Amedeo Giorgi, 1931 -) and the existential approach (Hans-Georg Gadamer, 1900 - 2002).

De Witt and Ploeg (2006) describe two forms of tensions; without and within phenomenology. Tensions without include those between phenomenology and other qualitative methods (Maggs-Rapport, 2001) and those within include the debate between advocates of descriptive and hermeneutic approaches (Cohen and Manion, 1994;

Annells, 1999; Corben, 1999). This chapter has compared and contrasted phenomenology with other qualitative methodologies, specifically ethnography and grounded theory, and has justified its use to inform this enquiry. Tensions within phenomenology will be explored below; the chapter will continue with an overview of the origins and development of phenomenology as a research approach and will consider the descriptive and existential approaches to research in relation to this thesis.

5.1 Edmund Husserl (1859-1938) and Descriptive Phenomenology

Phenomenology is attributed to the German philosopher Edmund Husserl who studied mathematics and philosophy, with a specific interest in fundamental issues concerning the sciences and their crucial concepts. He introduced phenomenology, as a new philosophical approach in 1900, and continued to develop it throughout his life, publishing numerous papers. Husserl challenged empiricism, which was the dominant philosophy at the time, by challenging the assumption that the world could be understood as an objective truth (Giorgi, 2006). Husserl considered consciousness to be the main focus of phenomenology and set out to understand the way that humans understand the world through consciousness. He proposed that: “human consciousness originally constitutes meaning through pre-reflective acts of perception, imagination and language” (Kearney, 1994, p.12). Husserl supported the notion of intentionality, as proposed by his teacher, Brentano, which can only be applied to conscious beings and not to physical things. Husserl (1970) described all mental acts as being intentional because they focus on an object that is not consciousness itself, these objects include memories and anticipations, not just physical objects. Lifeworld was first explicated by Husserl and then further explicated by Hiedegger It refers to the

human world of lived experience, which is concretely and directly given in experience, prior to theoretical explanations (Moran, 2000).

Husserl (1970) was interested in language, in that it can conceal and reveal phenomena and concluded that that experience could be uncovered through reflection on phenomena in consciousness, while suspending judgement and theories of consciousness (*epoche*). He developed a philosophy without pre-suppositions which went 'back to the things themselves' (*Zu den Scahen*) and stressed the prime importance of the discovery and exploration of the phenomena given in consciousness. Consequently, Husserl developed a systematic method, descriptive phenomenology, to investigate the structures of consciousness (Moyle and Clinton, 1997).

Husserl sought to establish a science of the understanding of essences rather than of facts (Annells, 1999) and he viewed the essence of the phenomenon as being the relationship of the subject to the object (Corben,1999; Koch, 1999). To identify the essence of a phenomenon, the researcher explores specific contexts and then develops a general concept (essence) from these. This research approach is considered to be the study of phenomena as they are experienced, with the emphasis on the phenomenon itself as experienced by the participant (Moyle and Clinton, 1997). Phenomenological research has been defined as: "an approach to human inquiry that emphasises the complexity of human experience and the need to study that experience holistically as it is actually lived" (Polit and Hungler,1995, p.649). This approach involves in-depth, audio-taped conversations or written anecdotes of personal experiences and is appropriate for research questions that seek meaning and to elicit the essence of experiences (Denzin and Lincoln, 1994). This was, therefore, considered to be the most

appropriate approach to explore students' experiences of learning from patients and clients during practice placements.

5.2 Amedeo Giorgi and Descriptive Phenomenology (1931-)

Two distinct approaches to phenomenological research evolved from Husserl's underlying philosophy, descriptive and interpretative. Although both are concerned with meanings and their discrimination, Giorgi (1992) strongly advocates the descriptive approach, arguing that: "a descriptive attitude implies a certain necessity demanded by saying that one describes what presents itself precisely as it presents itself, neither adding nor subtracting from it" (p.121).

He explains that his method encourages open ended dimensions in respondents' experiences, rather than trying to control them in the way that quantitative approaches do. In contrast, interpretative phenomenology is said to passively or actively bestow meanings onto the data (Giorgi,1989a). Giorgi added structure to Husserl's original descriptive phenomenology (Corben,1999) and his method aims to describe the phenomenon as it is described by a person in an everyday situation without using theories (Giorgi, 1985a; 1985b; Giorgi and Giorgi, 2003b).

> We should not enter research situations with our categories, as mainstream researchers usually do, but emerge with them after a careful analysis of a rich concrete description. One will then find a degree of complexity that a single word cannot easily capture.
>
> (Giorgi, 2006, p.11).

This involves the processes of description, by which the raw data is obtained; of phenomenological reduction, which involves the researcher bracketing existing knowledge when analysing this data; and the identification of the essence of the phenomenon. Theobald (1997) contends that this method assists in detailing the unhindered descriptions of the nature of the individual experience. Wallin and Gerd (2005) support this view, they conclude that Giorgi's analytical method is an effective approach to describe lived experience through the subjects' narratives and that the rigorous analysis ensures that findings are faithful to the text without interpretations on the part of the researcher.

Giorgi (2006) contends that his approach is not reductionist and argues that: "the full humanness of each participant in research should be allowed to be present in psychological research" (p.9). He suggests that the only relevant difference between the researcher and a participant is one of role in a co-operative situation. Although he acknowledges that the research interview is a limited situation, the participant should feel free to participate in the manner he or she wishes, including withdrawing from the research. Giorgi acknowledges the subjective nature of data collection. However, as will be discussed in the following chapter, he strongly contends that the researcher should be objective and scientific in the analysis of this data. This was considered relevant to the research enquiry, but before making a final decision on research approaches, the existential approach proposed by Heidegger (1977) and further developed by Gadamer (1989) were considered.

5.3 Martin Heidegger (1889-1976) and Existential Phenomenology

Martin Heidegger was a student of Husserl's and challenged the proposition that consciousness explained knowing. Rather, he argued that 'we are all in the world a priori to conscious knowing' (Walsh, 1996, p.232.). Husserl insisted that the researcher suspends belief in the outer world and that this reality is neither confirmed nor refuted, but is rather 'bracketed' within the process of phenomenological reduction (Koch, 1995). However, Heidegger (1977) believed that individuals are inseparable from the world and this led him to deviate from Husserl's descriptive phenomenology in favour of a hermeneutic approach. This approach does not advocate that the researcher brackets prior knowledge and understanding, but rather that he or she uses this to interpret respondents' experiences. Heidegger considered that the natural attitude is always integral to knowing and argued that reduction is impossible because all individuals are present in the world (Rapport and Wainwright, 2006).

5.4 Hans-Georg Gadamer (1900-2002) and Existential Phenomenology

Gadamer (1989) presented a dynamic process which emphasised the interaction between researcher and respondent. This dynamic interaction is presented as a hermeneutic circle, with constant interplay between the parts and the whole, which is in contrast to Husserl's reductionist approach described above. In this approach, understanding occurs through language and relies on the development of shared understanding between the researcher and respondent. Gadamerian philosophy emphasises the key constructs of dialogue, hermeneutic circle and fusion of horizons. This incorporates the socio-historical influences of both researcher and respondents and

the researcher has an explicit role in the interpretation process. Gadamer (1989) argues that this interpretation has two distinct aspects – 'pointing to' and 'pointing out'. The aspect of 'pointing out' meaning implies that the researcher interprets the data to reveal something that is concealed.

This is in contrast to Giorgi's approach, discussed above, in which the researcher presents the findings in the voice of the respondents without this additional aspect of interpretation. Giorgi (2006) argues that the participant is the expert in relation to the phenomenon under investigation: "the researcher may know theories and the literature, but he or she does not know the relevant dimensions of the concrete experience being reported by a participant" (p.10). This is directly relevant to the context of this thesis; the researcher has extensive experience of leading professional education programmes and extended her theoretical knowledge, during this research study, by critically reviewing relevant literature. This quote is consistent with the researcher's philosophical stance that students' knowledge and experience should be valued in the education process. A previous research study, using the same approach to explore students' perceptions of learning in practice settings, provided rich data in relation to their experiences (Gidman, 2001a; 2001b). The researcher was able to use questions to probe within the interview process itself, to enable the respondents to clarify issues, rather than interpreting these from the data during the process of analysis.

6. Conclusion to Chapter

This chapter has presented an overview of the paradigms of positivism, post-positivism, critical reality and constructivism and applied these to the focus of the thesis. The lack

of empirical evidence in relation to learning from patients and clients in practice settings led to the decision to conduct an exploratory study, rather than to generate theory. It is evident that the focus of this enquiry on the meaning of experiences in students' own terms, is not consistent with the positivist or post-positivist paradigms. The research aim is consistent with both the critical theory and constructivist paradigms, in respect of the subjectivist nature of the relationship between the researcher and participants. However, constructivism, with its focus on individual experiences of reality was considered to be the most appropriate to the research focus; that is, to explore the meanings of learning from patients and clients.

The chapter then provided an overview of qualitative research and critically evaluated the qualitative approaches of ethnography, grounded theory and phenomenology, in relation to the specific research aim:

- To explore pre-qualifying, nursing, midwifery and social work students' perceptions of learning from patients and clients in their practice placements.

Ethnography and grounded theory were both relevant to the context of the research but phenomenology was considered to be the most appropriate to address the specific aim of this enquiry. The descriptive phenomenological approach of Edmund Husserl and its application to a research method by Amadeo Giorgi were presented and were followed by the existential approach of Martin Heidegger and his follower, Hans-Georg Gadamer. The decision to adopt a descriptive phenomenological approach for this research enquiry was outlined. It was considered most relevant to this study because it emphasises the importance of presenting the data in respondents' own terms without interpretation by the researcher. This is consistent with the researcher's own philosophical stance in relation to research: that students' experience provides a

valuable form of knowledge to inform pedagogical research. The descriptive phenomenological research approach, as described in detail by Giorgi (1989a; 1989b; 1992; 2000c) was, therefore, used to determine and describe the design and methods of the study. This will be discussed in detail in the following chapter, which will report on the conduct of this research study.

The researcher reviewed other published papers using Giorgi's descriptive phenomenological approach to develop an understanding of its contemporary application. This study applies the approach to a new phenomenon; that is, learning from patients and clients in practice settings and it is anticipated that this will contribute to the development of the method in health and social care education. As will be evidenced in subsequent chapters, this was an effective approach to elicit data from students about their experiences.

Chapter 5: Design and Methods

1. Introduction to Chapter

The previous chapter considered the research paradigms of positivism, post-positivism, critical reality and constructivism and concluded that constructivism was the most appropriate paradigm for the focus of this research. Following a review of ethnography, grounded theory, descriptive and existential phenomenology, it was argued that descriptive phenomenology was the most relevant to the aim of this enquiry. This chapter will further explore Giorgi's descriptive phenomenological research method, which has been widely published (Giorgi, 1985a; 1985b; 1988; 1989a; 1989b; 1989c; 1992; 1993; 1994; 1995; 1997; 1999; 2000a; 2000b; 2000c; 20006; Giorgi and Giorgi, 2003a; 2003b) and will describe how this was applied in practice. This approach was found to be relevant to the context of the enquiry and elicited a large volume of rich data in relation to student learning from patients and clients in practice settings. This chapter will present the design and methods used in this study. Subsequent chapters will then present the themes and categories extrapolated from the data and will discuss these in relation to the literature reviewed earlier in this thesis. This chapter will include an overview of the pilot study access, consent and ethical considerations, the recruitment and sampling strategy, data collection and data analysis processes.

The descriptive phenomenological approach required purposive sampling, to ensure that all participants had experienced the phenomenon under investigation and that the researcher developed and implemented a recruitment and sampling strategy to maximise participation. The ethical implications of the research were an important consideration in this study and the researcher was aware of her reciprocal obligations to

the participants (Morse, 1994). Approval for this study was obtained from the Faculty of Health and Social Care Research Ethics Committee and this chapter will demonstrate adherence to the ethical criteria of beneficence, avoidance of malificence, equal opportunity, informed consent and technical competence (RCN, 2004).

The research design involved unstructured, conversational interviews, which elicited a large amount of rich data relating to learning from patients and clients. The pilot study for this thesis was a previous study by the researcher which explored student learning in practice settings using a descriptive phenomenological approach (Gidman, 2001a; 2001b). This was useful in developing the researcher's interviewing skills and in applying the data analysis techniques. The data analysis process described by Giorgi (1989b; 2000c) was applied rigorously to the data to ensure the quality of the study. Previous experience of using the method enabled the researcher to develop her skills in bracketing to facilitate this process. Issues relating to methodological rigour will also be addressed in relation to the criteria of credibility, fittingness, auditability and confirmability (Sandelowski, 1993). Although it is acknowledged that the findings of this research cannot be generalised to other populations, the study produced valuable data, which adds to the existing body of knowledge in relation to students learning from patients and clients.

2. Descriptive Phenomenological Approach – Amedeo Giorgi (1931-)

As discussed in the previous chapter, phenomenology as a research method has its roots in the philosophy of Husserl (1859-1938). Husserl sought to establish a science of the understanding of essences rather than of facts (Annells, 1999) and he viewed the

essence of the phenomenon as being the relationship of the subject to the object (Corben,1999; Koch, 1999). To identify the essence of a phenomenon, the researcher explores specific contexts and then develops a general concept (essence) from these. The two distinct approaches to phenomenological research which evolved from Husserl's underlying philosophy; that is, descriptive and existential, were considered in relation to this research study. The previous chapter concluded that the descriptive approach proposed by Giorgi (1989b; 1999; 2000c; Giorgi and Giorgi, 2003b) was appropriate to this research study because of its focus on presenting the experiences of the respondents without interpretation by the researcher. Giorgi advises that researchers should use an open-ended interview to elicit the data and cautions that it is the meaning of facts, as uncovered by the researcher, rather than the facts per se which are of importance.

Descriptive phenomenology emphasises an in-depth and immediate exploration of the phenomenon under investigation and this approach enabled the researcher to gain an insight into learning from patients and clients, from the perspectives of the students interviewed. The researcher discussed these experiences with the students directly, during placements in the third year of their programmes of study, to ensure that they were immersed in the experiences at that time. Descriptive phenomenology involves in-depth personal descriptions of experiences and the researcher paid particular attention to the ways in which the respondents described their interactions with patients and clients. One of the most detailed aspects of Giorgi's approach (1989b; 2000c) is the focus on a scientific approach to data analysis. Data analysis involves phenomenological reduction, which ensures that the findings of the study are presented in terms of the meanings of the experiences for the respondents, without interpretation by the researcher. This will be outlined later in this thesis, in relation to the data

obtained, in the format of the two themes and six categories extrapolated. Because descriptive phenomenology concentrates on respondents' own words, in ordinary language, it was particularly relevant to explore students' perceptions of learning in the context of this study.

This descriptive phenomenological approach has been used by a number of other researchers in health and social care settings and it is becomingly increasingly popular in Scandanavian countries (Giorgi 2000a; 2000b). These are summarised in Table 6 below, which demonstrates that Giorgi's method has been used effectively to explore a range of phenomena, including the experience of internal radiation treatment for uterine cancer (Kwok-wei and Chui, 2007); adolescents' experience of living with diabetes (Huus and Enskar, 2007); the experience of owning a guide dog (Wigget-Barnard and Steel, 2007); the experiences of spouses of partners who have suffered a myocardial infarction (Theobald,1997); the perceptions of the providers of health care in New Orleans following Hurricane Katrina in 2005 (Lafuente, Eichaker, Chee and Chapital, 2007); the experiences of people of living with Parkinson's disease (Sunvisson, 2003); the experience of chronic pain and fibromyalgia (Raheim and Haland, 2006); the experiences of young adult refugees in Sweden (Wallin and Gerd, 2005); women with psychoses experiences of occupational therapy (Ivarsson, Soderback. and Ternestedt, 2002); the experiences of being in a family when one member of the family is terminally ill (Syren, Saveman and Benzein, 2006); the experiences of liver transplant patients (Del Barrio, Lacunza, Armendariz, Margall and Asaiin, 2004); and the experience of memory loss following electro- convulsive treatment (Moyle and Clinton,1997).

Table 6: Summary of Research Studies Using Giorgi's Descriptive Phenomenological Method

Authors	Focus of study	Place of study	Sample	Findings
Baker, C., Arseneault, A.M. and Gallant, G. (1994).	Resettlement without the support of an ethno-cultural community	Canada	Twenty immigrants	Four themes: • Propelled into a new culture • Sudden cultural immersion • Trying to get a foothold • Orientation towards the future
Blomberg, K. and Sahlberg-Blom, E. (2007)	Closeness and distance: a way of handling difficult situations in daily care	Sweden	Sixteen focus groups	Identified closeness and distance with variations in terms of identity, meaning, limit setting, touching, prioritising, team and organisation
Del Barrio, M., Lacunza, M.M., Armendariz, A.C., Margall, M.A. and Asiain, M.C. (2004)	Liver transplant patients: their experience in the intensive care unit	Spain	Ten liver transplant patients	Five themes: • Predispositions marked the way they approached transplant • Captured impressions of ITU environment • Perceptions of caring behaviour of staff • Social support and religious beliefs • Preconceived view of ICU differed from experience
Huus, K. and Enskar, K. (2007)	Adolescents' experience of living with diabetes.	Sweden	Eight adolescents	Five themes: • To be different • To be treated differently • To live a regular life • To know one's body • To take care of oneself

Table 6: Summary of Research Studies Using Giorgi's Descriptive Phenomenological Method

Ivarsson, A., Soderback, I. and Ternestedt, B. (2002).	The meaning and form of occupational therapy as experienced by women with psychoses	Sweden	Six women with psychoses	Two structures: • How intervention affected women • How they experienced the arrangement of the intervention
Knoche, L.L. and Zambagoanga, B.L. (2006)	College student mentors and Latino youth: a qualitative study of the mentoring relationship.	United States.	Six mentors	Three clusters: • The characterisation of the relationship • The meaning of the relationship with the family • The mentor's personal and professional development
Koivisto, K., Janhonen, S. and Vaisanen, L. (2002).	Psychiatric nursing.	Finland	Nine voluntary adult patients recovering from psychosis	Five situated structures: • Feelings of changing one's self • Feelings of a loss of control • Emotional feelings • Physical feelings • Difficulties to brief and other
Kotze, H.N. (2006)	Psychology of forgiveness: an interpersonal perspective	South Africa	Three people with stories of forgiveness – identified by clinical psychologists	Five themes: • Emotional discomfort • Blame and uncertainty • Shift to empathy • Forgiveness as process • Lasting change or forgiveness incorporated into way of life
Kwok-wei, W. and Chui, Y. (2007)	Women's experience of internal radiation treatment for uterine cervical cancer.	Hong Kong	Eight women with uterine cancer	Three themes: • Isolation versus social intercourse • Unbearable symptom distress versus endurance and coping Growth from the experience.
Lafuente, C.R., Eichaker, V., Chee, V.E. and Chapital, E. (2007)	Post-Katrina provision of healthcare to veterans in a mobile clinic: providers' perspectives	New Orleans	Eight health care providers	Three themes: • Uncertainty • Deprivation • Stabilisation

Table 6: Summary of Research Studies Using Giorgi's Descriptive Phenomenological Method

Raheim, M. and Haland, W. (2006)	Lived experience of chronic pain and fibromyalgia: women's stories from everyday life.	Norway	Twelve women with chronic pain/ fibromyalgia	Three typologies: • Powerlessness • Ambivalence • Coping
Sunvisson, H. (2003).	The embodied experience of living with Parkinson's disease	Sweden	Eleven people with Parkinson's disease	Striving for involvement within an experience of changing habitual skillfulness and changing horizons.
Syren, S.M., Saveman, B. and Benzein, E.G. (2006)	Being a family in the midst of living and dying	Sweden.	Thirteen members of family of terminally ill person	Six categories emerged which, in pairs, were a dialectic and dynamic relation to each other
Theobald, K. (1997)	The experience of spouses whose partners have suffered a myocardial infarction.	Australia	Three spouses	Five themes: • Crushing uncertainty • Overwhelming emotional turmoil • Need for support • Lack of info heightened anxiety • Acceptance of lifestyle changes
Wallin, A.M. and Gerd, G.I. (2005)	Unaccompanied young adult refugees experiences of their life situation and well-being.	Sweden	Eleven young adult refugees	Wallin and Gerd (2005) interviewed in using Giorgi to explore their experiences. Nine themes • Work/education • Starting a family • Loss of family • Thoughts about new language • Coping • Social network • General well being • Thoughts about the future • The meaning of the term 'successful'

Table 6: Summary of Research Studies Using Giorgi's Descriptive Phenomenological Method

Wigget-Barnard, C. and Steel, H. (2007)	The experience of owning a guide dog	South Africa	Six people with a guide dog	Eight themes: • A guide dog improves mobility • A guide dog provides companionship • A guide dog necessitates personal change • Lifestyle change result from guide dog ownership • A guide dog is social magnet • Distractions inhibit the guide dog guiding • Ignorance regarding guide dogs • Source of pride to owner

These examples support the application of this approach to explore respondents' experiences and to provide rich data in relation to the focus of the research study. Although the findings of the studies were all context specific, they all explored experience and reported that the descriptive phenomenological approach was appropriate for this purpose. These research reports were used to influence the choice of sample in this study and to determine the presentation of data in terms of themes and categories. The studies summarised in Table 6 demonstrate sample sizes of between three and twenty, with the most common sample size of six respondents. None of the studies identified the essence of the phenomenon under investigation, but rather presented the data in themes (also termed clusters and structures) with sub-themes or categories.

Table 6 includes the previous study by the researcher which was referred to above (Gidman, 2001a; 2001b). This was considered as the pilot study for the planned research and will be discussed in further detail below.

3. Pilot Study

Pilot studies are recommended for qualitative research approaches in order to focus on particular areas which may have been unclear, to test questions and to test the adequacy of the data (Janesick,1994). This provides an indication of the possible responses of participants and of the appropriateness of the research design and methods. However, Morse (1997) questions the value of pilot studies

for qualitative research approaches because it is extremely limited in terms of the relevance of the data obtained to the findings of the main study. It was, therefore, not considered appropriate to test the specific research question for this research with a single pilot respondent prior to the main study.

The research study discussed earlier (Gidman, 2001a; 2001b) was considered to be the pilot study for this PhD research. This study was conducted to fulfill the requirements of a Master of Education dissertation and also attracted funding from the Welsh National Board for Nursing, Midwifery and Health Visiting in the form of a Research Training Fellowship. As part of this Research Training Fellowship, the researcher attended a five day workshop on phenomenology led by Professor Amedeo Giorgi (Appendix 2) and consequently applied his approach to the study. An initial interview was undertaken with a nurse lecturer from another institution, who was using a descriptive phenomenological approach for her Ph.D. studies. This provided constructive feedback regarding the researcher's interview technique and her application of the method which influenced the approach to the student interviews, in order to elicit deeper discussions of their experiences.

Eight pre-registration nursing students were interviewed, using an open question to explore their experiences of learning in practice settings. Interviews were tape recorded and transcribed and extensive data were obtained which provided rich descriptions of learning in practice settings. The major strength of using this approach is that it encouraged students to openly and honestly describe their

own experiences. The interviews produced a large amount of data, which included students' feelings and provided insight into the meanings of their experiences of clinical learning. The variety of descriptions given by the students indicated that learning during clinical placements was an individual experience and that no two students experience the same placement in the same way. One of the surprising findings from this research study was that all students described experiences in which they had learned from patients during their practice placements. However, these learning experiences were largely not facilitated by mentors or lecturers. Presentation of the findings of this research, at both local and national conferences, promoted interest in nursing students' descriptions of learning from patients and it was evident that this was an aspect of student learning worthy of further research.

As discussed in the previous chapter, the original intention of this PhD thesis was to model the processes involved when students learned from patients and clients, therefore, a range of paradigms and research approaches were considered. However, following the literature review the research aim was finalised and the Master's dissertation referred to above was considered to meet the requirements of a pilot study because it focused on a related subject, used the same research methodology, design and method and produced relevant data.

The research design and methods will now be described in relation to the recruitment and sampling strategy, access, consent and ethical considerations,

data collection methods and data analysis approach.

4. Sampling and Recruitment Strategy

The sampling procedure in qualitative research is less rigidly prescribed than in quantitative research, but the sample selection has a major effect on the ultimate quality of the research (Coyne, 1997). The sample for this study was selected from the population of undergraduate nursing, midwifery and social work students within the researcher's own institution. Morse (1994) argues that, in qualitative research, the sample should be selected according to the needs of the study and not according to external criteria, for example random selection. The sample selected was, therefore, representative of the experience or knowledge under investigation; that is, learning in practice settings, rather than a demographic reflection of the general population.

Becker (1992) contends that the phenomenological viewpoint is based on two premises:

1. that experience is valid and a fruitful source of knowledge;
2. that our everyday worlds are a valuable source of knowledge.

To ensure that the sample was appropriate to these two premises, the researcher used purposive sampling and approached groups of students whom she knew had relevant and recent experience: the ability to express themselves

linguistically; the ability to sense and express inner feeling and emotion; the ability to sense and express organic experiences that accompany these feelings; spontaneous interest in the experience; and the ability to report what was going on within themselves. This was achieved by approaching groups of undergraduate nursing, midwifery and social work students who were in the final year of their programmes. To increase participation, the researcher developed a sampling and recruitment strategy to target a purposive sample and to maximise participation in the interviews. This strategy addressed the stages of preparation, contact and follow-up, as proposed by MacDougall and Fudge (2001). These authors advise that the preparation stage involves identifying information sources and key contacts, identifying related projects and considering alternative samples. The contact stage involves negotiation with these key contacts and with potential participants and plans for continued involvement. The final, follow-up stage, involves feedback and continuing links. It also involves presentation of the findings at public events and any actions resulting from the research. It is acknowledged that these stages are time consuming and require considerable time and resources, but this was considered to be an essential part of the research process, to ensure the selection and recruitment of an appropriate sample. This strategy is outlined in Table 7 below and was found to be very useful in terms of ensuring that an appropriate population was targeted to participate in the study. Early contact with the Heads of Education Centres (later called Heads of Department) was invaluable in arranging both access to the student groups and to arrange the interviews in appropriate settings.

Table 7: Sampling and Recruitment Strategy (adapted from MacDougall and Fudge, 2001)

Strategic Plan	Operational Activity
Prepare:	
1. Describe the sample	1. Final year nursing, midwifery and social work students
2. Identify key contacts	2. Research supervisor/Head of Education Centre/Dean of Faculty/programme leaders
3. Identify related projects	3. No other research studies involved sample at time of study
4. Draft alternative strategies	4. Potential to access alternative Education Centres (not own)
Contact:	
1. Initial approach	1. Target population identified/Access and ethical considerations considered
2. Negotiation with key contacts	2. Formal letter to Dean of Faculty requesting access to students/Ethical approval granted by Faculty Ethics Committee
3. Direct negotiations	3. Short presentation to students

	followed by information leaflet and invitation to participate and consent forms/assurance of anonymity and confidentiality
4. Confirmation	4. Fifteen completed forms received/time and location of interview negotiated
5. Involvement	5. Interviews conducted in informal settings
Follow Up;	
1. Feedback to and from participants	1. Further explanation by researcher of aims, process and data handling in study/opportunity to withdraw data taken up by one respondent
2. Feedback to key contacts	2. Findings discussed with supervisors and presented to relevant Faculty staff
3. Continuing links	3. Research supervisors and Faculty staff
4. Public events	4. Presentation of initial findings at national and internal conferences
5. Action and advocacy	5. Work with Heads of Department and programme leaders to implement findings.

The researcher originally intended to ask students, who agreed to participate in the research, to write a short account of an experience of learning from patients and clients during their practice placements, which had a major impact on them and to select participants on the basis of the accounts provided. However, after approaching the groups, only fifteen students volunteered and these were all, therefore, included in the sample, to allow for some attrition during the study. All students had the necessary experience of learning in practice settings and the researcher had to make the assumption that, by virtue of achieving learning outcomes throughout their programmes, they also had the abilities highlighted above (Becker, 1992).

The total population of students for this study comprised one cohort of nursing students, including adult, child, mental health and learning disability branches (n=115); one cohort of midwifery students (n=26); and one cohort of social work students (n=22). As previously discussed, the researcher was interested in sampling all pre-qualifying students within the Faculty, to improve her own knowledge base and to conform to the current context of integrated health and social care. In practice, this led to increased work for the researcher, in terms of reviewing literature and policies and accessing student groups. It also led to potential bias in terms of the researcher's own expertise in nursing. However, it is important to reiterate that this research is not intended to be a comparative study. The aim is to explore students' perceptions of learning from patients and clients in practice settings, as broadly as possible.

The final sample size was twelve students (three of the original fifteen participants withdrew from the study before it commenced) and it comprised six nursing students, three midwifery students and three social work students. Despite the rigorous sampling strategy adopted, the researcher acknowledges that due to smaller numbers of volunteers than anticipated, the final sample may be considered to be a convenience, rather than a purposive one. This will be discussed further within the limitations section of the thesis.

Twelve respondents is considered an appropriate sample size for phenomenological research, which aims to obtain extensive data from a small sample, as opposed to superficial data from a large sample (Denzin and Lincoln, 1994). Indeed, Morse (1994) advocates conducting interviews, in the form of in-depth conversations, with approximately six participants within a phenomenological research strategy. This is consistent with published research studies using the same approach, with reported sample sizes of three (Theobald, 1997), six (Ivarsson et al*,* 2002; Wigget-Barnard and Steel, 2007), eight (Huus and Enskar, 2007; Kwok-wei and Chui, 2007; Lafuente et al., 2007), ten (Del Barrio et al., 2004), eleven (Sunvisson, 2003; Wallin and Gerd, 2005), twelve (Raheim and Haland, 2006), thirteen (Syren et al*.,* 2006) and twenty (Baker et al*.,* 1994).

The researcher considered that the adequacy and appropriateness of data were the most important considerations. Morse (1994) describes adequacy as being the amount of data collected, as opposed to the number of subjects; and appropriateness is defined by the theoretical needs of the study. In this study, the interviews lasted between sixty and ninety minutes and were transcribed to between twenty five and forty three pages of data for each subject, which the researcher considered to be adequate. Although each transcript was individual, they all described learning from experiences involving patients and clients, which was the basis of the study and, therefore, considered appropriate.

5. Access, Consent and Ethical Considerations

As previously stated, approval for this study was obtained from the Faculty of Health and Social Care Research Ethics Committee (see Appendix 3). The researcher sought advice from Research and Development departments in local Trusts and was advised that, because the study did not involve patients, clients or staff, ethical approval was not required from practice organisations.

The ethical implications of the research were an important consideration in this study and the researcher was aware of her reciprocal obligations to the participants (Morse,1994). During the research study the welfare and rights of participants were of prime importance and participation was only permitted after voluntary and informed consent had been obtained (see Appendices 4 and 5).

Participants were informed of the nature of the study beforehand and were assured that they could withdraw at any time. This was reinforced before the interviews, which were tape recorded only after explicit consent to this was obtained; confidentiality was assured and data remain anonymous. All participants were all informed of the findings on completion of the study if they requested this (see Appendix 5).

The Royal College of Nursing (RCN) criteria of beneficence, avoidance of malificence, equal opportunity, informed consent and technical competence (RCN, 2004) were used to ensure that the study adhered to these ethical imperatives.

5.1 Beneficence

The aim of the study was to explore pre-qualifying, nursing, midwifery and social work students' perceptions of learning from patients and clients in their practice placements. It is anticipated that the findings of this study will influence the delivery of nursing, midwifery and social work pre-qualifying programmes, to develop a strategic approach to patient and client involvement in practice learning and to positively impact on the student experience. Prospective participants were informed of the potential benefits, both for themselves and for future students. All the respondents expressed the view that practice learning was an important aspect of their programmes and most used the opportunity to

highlight issues which had impacted on this. The researcher assured all respondents that these issues would be addressed, in order to improve the experience for future students.

5.2 Avoidance of Malificence

Participation in the research was entirely voluntary and no students were disadvantaged either by participation or non-participation in the study. Confidentiality was assured at all times and all data were anonymous when reported and discussed with the research supervisors. The requirements of the Data Protection Act (Her Majesty's Government, 1998) and those of the University were adhered to at all times. Students were approached personally within the University and their personal details were not accessed at any time. They were also made aware of the procedures in place to store data and to destroy the raw material on completion of the PhD thesis. The research was not conducted at the researcher's own education centre to ensure that students did not feel pressurised to participate in any way. The interviews were arranged at a time and venue appropriate to the students, these included staff rooms in practice organisations and classrooms/meeting rooms in the University.

The researcher was sensitive to the possibility that students may refer to difficult experiences in practice and provided debriefing opportunities to ensure support. This was the case for two students who became upset after disclosing their feelings about specific experiences; the researcher offered to terminate these

interviews, but this was refused in both cases. Following the interviews the researcher spent time with each of these students to provide support and this discussion was not tape recorded or transcribed. The researcher has considerable experience of supporting students in both practice and university settings and also referred them to their own personal academic tutors (with their consent) for further support. The University policy was used as guidance to ensure that the researcher did not abuse the potential power imbalance and to address any incidents of poor practice or complaints (University of Chester, 2008).

All respondents were informed, at the start and completion of each interview, that they could withdraw any data if they so wished. One respondent (R3) asked for the details of a distressing experience involving a failed resuscitation attempt on a baby to be withheld and this was, therefore, not transcribed. Support and debriefing opportunities were available for all students and this particular respondent did engage in this.

5.3 Equal Opportunity

All students selected within the population based at the education centres had equal opportunity to participate in the research. There were no adverse effects for students who chose not to participate or withdraw from the study at any time.

5.4 Informed Consent

As discussed above, written consent was obtained from all participants at the time of volunteering and immediately prior to data collection (Appendices 4 and 5). Participation in the study was entirely voluntary and prospective participants were fully informed of the aims of the study, the design, methods and tools used and the access to data and publication of findings.

5.5 Technical Competence

Pilot studies are recommended for qualitative research approaches in order to focus on particular areas which may have been unclear, to test questions and to test the adequacy of the data (Janesick, 1994). Feedback, from both an initial pilot interview and the Master of Education research dissertation, was used to develop the researcher's expertise in both interviewing and the data analysis approach. The current study was also overseen by experienced research supervisors and an external advisor to ensure technical competence throughout.

The researcher was aware, throughout all stages of this thesis, that she had a continuing responsibility to ensure adherence to the ethical criteria described above. This was assured by the researcher keeping a reflective diary and by regular discussions with supervisors throughout the development of this thesis. The researcher was also aware of her own professional accountability, within the

Nursing and Midwifery Council Code of Conduct (NMC, 2008b), to the patients and clients described by students in the interviews. There were several examples given by students of practice which was not ideal, which prompted the researcher to question this further after the interview had been completed and the tape recorder had been turned off. The students had addressed their concerns with practice managers following these incidents and, therefore, no further action was required by the researcher.

6. Data Collection Methods: Unstructured Interviews

The fifteen students who agreed to participate in the research were contacted and individual interviews were arranged at times and venues which were convenient for them. The interviews took place between May and September 2005, and were recorded using audio tapes with the researcher completing additional notes immediately after each one. Interviews are widely used within qualitative research and may invoke a structured or unstructured approach (Wengraf, 2001). Structured interviews involve the interviewer asking respondents a series of pre-determined questions, which limit responses; the process is controlled by the interviewer and allows little flexibility (Denzin and Lincoln,1994). This emphasis on interviewer control and limited response would not be appropriate for the descriptive phenomenological approach, which emphasises understanding in terms of the subject's experience and not the interviewer's interpretation of that experience (Giorgi,1992). In contrast,

unstructured interviews provide a flexible means of gathering data, to enable the researcher to understand the respondent's experience and to produce greater breadth and depth of data. The unstructured interview is described as: "a conversation, the art of asking questions and listening" (Denzin and Lincoln,1994, p.353).

The researcher used unstructured, audio-taped interviews to collect the data for this study to ensure that in-depth information was obtained from respondents (Fontana and Frey, 1994). However, Wengraf (2001) cautions that the interview is not a normal conversation, rather it has a specific research purpose and must, therefore, be planned. It was considered important to help students to relax and to become accustomed to the situation, to enable participants to feel comfortable and to understand what the study was about, which was necessary if they were to provide accurate data (Morse, 1994). The participants chose the time and place for interviews, which were conducted in a quiet, comfortable room, with chairs arranged in an informal way and tea and coffee available. The interviews in this study were planned in terms of the opening question: "tell me about your experiences of learning in practice so far in your programme." This was designed to be a 'safe' question to put respondents at ease and to start the conversation. Once the respondents appeared to be relaxed, the researcher asked them to tell her about an experience of learning during their practice placements which specifically involved patients or clients: "tell me about your experiences of learning from patients or clients during your practice placements."

This was deliberately a very open question so as not to influence responses. As previously discussed, the researcher was experienced in using this approach and was able to use prompts appropriately to probe responses without leading or biasing the focus of the interview. Several students asked whether this should be a positive or negative experience and were advised that it could be either, provided that they felt that it had an impact on them. It is also important that, when conducting interviews, the researcher felt comfortable and confident, so that she was relaxed and could focus on what was happening in order to obtain valuable data. This was helped by the researcher's previous experience of interviewing, in both professional and research contexts and by the pilot study outlined above.

The researcher was cognisant of the fact that the interview itself is not neutral and was aware of her role and the effects of personal characteristics (Denzin and Lincoln,1994). In practice, the relationship between the researcher and the students encouraged open dialogue, although it is acknowledged that interest and commitment to practice based learning had the potential to bias her approach (Carr,1994). The researcher had actively developed her interview skills, particular in respect of active listening, and adhered to the focus of the research question whilst probing the respondent to expand on answers (Becker, 1992). The interview was conducted in a respectful, courteous manner, with the researcher offering only limited personal comments and advice and probing at suitable times (Creswell,1998).

Data was recorded using two audio tapes, as advised by colleagues who had lost data due to loss of function in tape recorders. The researcher explained to respondents at the start and completion of each interview, that they could withdraw any data if they so wished. One respondent asked that the specific details of a distressing neonatal death were not transcribed and this section of the tape is, therefore, not included in the data reported in this thesis.

7. Data Analysis

The interview tape recordings and transcripts were considered to be the raw data of the study and, as described above, each of these comprised between sixty and ninety minutes of audio tape recording and between twenty five and thirty nine pages of transcribed data. Giorgi (1985a; 1989b; 1995; 2000c) and Giorgi and Giorgi's (2003b) psychological approach to phenomenological research focuses on individual experience and assumes that there is an essential structure to the phenomenon and that a person has intentional behaviour and free will. The respondents' articulations, therefore, were directly translated into the raw data and the researcher listened to the audio tapes and read the transcripts numerous times to become immersed in the experiences before commencing any analysis of the data. This immersion in the data and experience of each individual enabled the researcher to familiarise herself with the data before identifying meaning units and applying phenomenological reduction to identify the essential themes of the phenomenon.

In keeping with Giorgi's (1992) approach, data analysis did not commence until all twelve interviews had been completed. Each experience is considered to be unique to the individual and the role of the researcher is to facilitate an open description of this experience as perceived by the subjects. This is part of the concept of 'bracketing' which ensures that the researcher was not influenced by her own knowledge and experience or by previous responses. In this study, this process was facilitated through reflective diary keeping and regular discussions with research supervisors.

Giorgi presents six stages of data analysis, which he developed by obtaining descriptions of the phenomenon of learning. The first stage is to read the entire description as a whole, in order to get a sense of the experience. The next stage involves returning to the beginning and reading the text in order to identify meaning units. The third stage is to identify the central theme within each meaning unit and then the fourth stage involves expressing these meaning units in terms of the phenomenon of interest. The fifth stage involves synthesising these transformed meaning units into a general statement of the subject's experience and the final stage is to extrapolate the essence of the phenomenon from these statements. These stages will now be discussed in more detail, with an explanation of how they were applied to the data obtained, using an example of a meaning unit taken from the transcript of Interview Eight (Appendix 6).

7.1 Gaining a Sense of the Whole

The first step in data analysis is to gain ‘a sense of the whole’. This is a straightforward step, involving: “a simple reading of text and the ability to understand the language of the describer” (Giorgi,1989a, p.10). The researcher had initially intended to transcribe all interviews in order to become immersed in the data and to fully understand it. However, due to time commitments, she transcribed the first five interviews, but then paid for clerical assistance to transcribe subsequent interviews. To overcome the problems of not transcribing all of the interviews herself, the researcher read each interview transcription several times, whilst simultaneously listening to the tape recording. This helped to identify any inaccuracies in the transcriptions and also allowed the researcher to immerse herself in the data, including intonations and pauses which often conferred meaning on statements.

7.2 Discrimination of Meaning Units

The second step involves the: “discrimination of meaning units within a psychological perspective and focused on the phenomenon being researched” (Giorgi,1989a, p.11). In this study, as with Giorgi’s many examples, the phenomenon under study was that of learning. After reading an interview transcript several times, the researcher noted on the text whenever she became aware of: “a change of meaning of the situation for the subject that appears to

be psychologically sensitive" (Giorgi,1989a, p.11).

An example of data comprising one meaning unit taken from the transcript from the interview with respondent eight is given below. The interview was recorded and transcribed verbatim, without correction of any grammatical errors.

Meaning Unit 24

J: Is there anything else that particularly sticks in your mind, any particular experiences that…….?

R8: The one experience that I got from general is that, because you got a fair few patients that would be admitted to the ward because they'd got a fracture and they'd be identified it's because they've got cancer because it goes into the bones doesn't it?

J: Pathological fracture, yes.

R8: And I was horrified at how long it then took to involve, because they were under consultant for orthopaedic, how hard it was to get the care for them for the cancer sort of thing. And erm, erm, pain relief even. I sort of, I thought, I mean the patients, unless they actually knew the system, wouldn't be aware that it was taking longer than it should. I found that very frustrating. I was involved with a lady who had been admitted, very poorly, had fractured her hip. And she was red carded because she was that poorly. So they weren't going to resuscitate and she pulled through. And, as she became well she was very chirpy, very independent, ninety

two. And she had got a lovely character, lived at home on her own and just as she was being discharged they discovered a lump in her breast. So she did get an appointment straight away and I escorted her down and that was an horrendous experience. Erm, the communication with the patient was zero. Erm, we went first to the breast clinic, they sent us along for a mammogram. She went back, they'd looked at it didn't tell her the results and then sent her down to have erm, I'm not going to tell you the terminology, but where they withdrew …

J: Fine needle aspiration.

R8: … and this, he was a doctor, she got the lump in her right breast and he went to do that one and she was compliant. And then he said "right, and the other one. And she said "I don't need it in the other one, I've only got the lump in this one". And he said "no you've got lumps in both breasts." And I said "I don't think Mrs X has been informed of this doctor". I was, I could have hit him round the head I could! I mean, you know, he probably, just gets blasé I suppose. And he said - "oh right, well you've got lumps in both breasts". And she just turned to me and she said "that's enough, I've lived long enough". And eventually she went "no I've had enough" and he went to do it again and I said "I think she's withdrawn her consent doctor". And I was welling up. And so I took her out and we went along and they told her they'd got to do another where they actually took erm…

J: Took tissue?

R8: Yes. And, which I thought was another horrendous experience. They injected her with anaesthetic and I said to the nurse afterwards, because they did that and then did the procedure straight away. And I said "does it not take a while, because I didn't think it should have hurt her and it did." And she said "oh it does take a little while". Because I was questioning his practice. And they didn't actually realise I was a student I think because I was mature.

J: You weren't in uniform?

R8: I was in uniform but I think,

J: Oh right.

R8: … so I was actually (turn tape over) deeply involved, there to explain to her and the doctor prescribed her hormones because there wasn't going to be any more treatment. And she was deaf but she seemed to be able to pick up, whether it was because she knew me and she had got confidence, so I had to relay all the time to her what was being said to her. And the doctor was Asian, so I don't think she could understand him. And, erm, he said "we're going to do this treatment". And I said "before I relay that doctor can you tell me" I said "is she's having this hormone treatment because of her age or because that is the best, because it's the best treatment for the form of cancer she's got". I said "in case she asks that question to me next" and he said "oh it's the best treatment" and I said, because I said "she might want to know why she's not having an operation because breast cancer presumably you were going to do some

operation". So I said "they've given you some tablets" and explained all that to her. She said to me, she said "I've had enough now, I've lived long enough". And I thought what a shame, she's now going to have to go into a nursing home and she lived independently. But the communication there I thought was absolutely zero. You know, somebody should have sat down from the mammogram and said "they've identified……I think there's more …." Nobody bothered to take that step. It's probably bad communication the fact that she was deaf. But she could hear if you took time out to talk to her.

J: What would you say you'd taken from that then?

R8: About how important communication is I think and about consent. Because people weren't listening to her. And all along it should be built into the care package shouldn't it, and consent in all the way through.

J: Yes.

R8: Because that's one of my son's horrors, because he has in the past been detained under the Mental Health Act, given electric, ECT without his consent can't they.

J: Take his control away?

R8: Yes and she was, she was very, you know, she knew what she was saying, "no I've had enough, I've lived long enough". I mean that's clearer than anything isn't it. But I said to her "are you sure, would you like to think about this?" "No I've lived long enough. Long enough now".

At this point, the student went on to discuss what happens when patients are discharged from hospital and this was identified as the start of the next discrete meaning unit.

7.3 Summarise Meaning Units

The third stage was to summarise the meaning units; this step does not involve changing the subject's language in any way. Meaning units were identified by being open-minded and being aware of when the meaning changed, in relation to the phenomenon of learning. This step allows spontaneity and discovery before the next step, in which the researcher analyses the meaning units identified.
The above meaning unit is summarised below:

> *R8 relates an experience on a general ward in which a patient was admitted with pathological fractures and was then diagnosed with breast cancer. She found it very frustrating that the patient had to wait for care and the way that the patient's wishes were disregarded. Care during diagnosis and communication with the patient were very poor and she was not informed that the lumps in both breasts were malignant. R8 recognised that the doctor was not listening to the patient's views and acted as her advocate. R8 recognises that her response was influenced by her son's experience of care for mental health problems.*

7.4 Transformation of Meaning Units

The fourth step in the process of data analysis is the: “transformation of the subject’s everyday expressions into psychological language with the emphasis on the phenomenon being investigated” (Giorgi 1989a, p.17). This step involves the processes of ‘reflection and imaginative variation’ to identify what is contained within the meaning unit in terms of the phenomenon under investigation. Imaginative variation requires the researcher to consider all possible meanings, not just accepting the first meaning that emerges from the data. This involved considering each meaning unit in relation to learning and identifying the central issue within it that incorporated learning. To do this, the researcher read each meaning unit several times and reflected on the possibilities, then decided on that which seemed to be consistent with the data. The meaning unit above was transformed into the following paragraph:

> *R8 reflects on a distressing experience in which a doctor’s attitude resulted in the patient withdrawing consent to treatment. R8 acted as the patient’s advocate with the doctor, her response was influenced by past experience.*

7.5 Situated Structure of Learning

The fifth step in the method involves the: “synthesis of transformed meaning units into a consistent statement of the structure of learning” (Giorgi, 1989a, p.19).

The situated structure of learning in this study, refers to the nature of learning in each students' individual experience. Giorgi suggests that this description should incorporate, at least implicitly, all of the meanings of the transformed meaning units. An example of a situated structure of learning is presented in Appendix 7.

7.6 Extrapolate the Essence of the Phenomenon

The final stage of analysis related to the extrapolation of the essence of the phenomenon under investigation. This research approach, based on Husserl's ideas, refers to phenomenological reduction, the search for essences and the process of description (Koch,1999). Husserl sought to establish a science of the understanding of essences rather than of facts (Annells,1999). Husserl viewed the essence of the phenomenon as being the relationship of the subject to the object (Corben,1999). To identify the essence of a phenomenon, the researcher needs to first explore specific contexts and then develop a general concept (essence) from these. This is achieved by examining the situated structures of learning, as described above, in order to identify the essential essence of this learning. This research study supports Paley's (1997) argument that, although the method can identify the essential nature of the phenomenon for a particular subject, in a particular situation, it does not produce an essential essence which is common to all experiences. The researcher was not able to identify an essential essence of learning from patients or clients, but did identify common themes. This is consistent with other examples of research which used Giorgi's

approach (Moyle and Clinton, 1997; Theobald,1997; Ivarsson et al.,2002; Del Barrio et al., 2004; Sunvisson, 2003; Wallin and Gerd, 2005; Raheim and Haland, 2006; Syren et al., 2006; Huus and Enskar, 2007; Kwok-wei and Chui, 2007; Lafuente et al., 2007; Wigget-Barnard and Steel, 2007). None of these studies elicited a single essence which was common to all experiences, but the researchers did identify themes in relation to the phenomena under investigation. Eight of these studies were particularly useful to the researcher, when determining the most appropriate way to present the extensive data, whilst remaining faithful to the intention to present this from the respondents' own perspectives. These papers are summarised in Table 8 below.

Table 8: Development of Themes in Published Research Studies Using a Descriptive Phenomenological Research Approach.

Authors	Title	Presentation of Data	Themes/categories/structures
Del Barrio et al. (2004)	Liver transplant patients: their experience in the intensive care unit: a phenomenological study.	5 themes	1. Predispositions marked the way they approached transplant 2. Captured impressions of ITU environment 3. Perceptions of caring behaviour of staff 4. Social support and religious beliefs 5. Preconceived view of ICU differed from experience
Huus and Enskar (2007)	Huus, K. and Enskar, K. (2007) Adolescents' experience of living with diabetes.	5 themes	1. To be different 2. To be treated differently 3. To live a regular life 4. To know one's body 5. To take care of oneself
Ivarsson et al. (2002)	The meaning and form of occupational therapy as experienced by women with psychoses.	2 structures with 11 key constituents	1. How intervention affected women: Relief/belief in future/self knowledge/capability/resistance/satisfaction 2. How they experienced the arrangement of the intervention: Time/environment/guidance/voluntariness/ Collaboration
Kwok-wei and Chui (2007)	Women's experience of internal radiation treatment for uterine cervical cancer.	3 themes	1. Isolation versus social intercourse 2. Unbearable symptom distress versus endurance and coping Growth from the experience

Authors	Title	Presentation of Data	Themes/categories/structures
Lafuente et al. (2007)	Post-Katrina provision of healthcare to veterans in a mobile clinic: providers' perspectives.	3 themes	1. Uncertainty 2. Deprivation 3. Stabilisation
Theobald (1997)	The experience of spouses whose partners have suffered a myocardial infarction: a phenomenological study.	5 themes	1. Crushing uncertainty 2. Overwhelming emotional turmoil 3. Need for support 4. Lack of info heightened anxiety 5. Acceptance of lifestyle changes
Wallin and Gerd (2005)	Unaccompanied young adult refugees in widen, experiences of their life situation and well-being: a qualitative follow up study	9 themes	1. Work/education 2. Starting a family 3. Loss of family 4. Thoughts about new language 5. Coping 6. Social network 7. General well being 8. Thoughts about the future 9. The meaning of the term 'successful'
Wigget-Barnard, C. and Steel, H. (2007)	The experience of owning a guide dog	8 themes	1. A guide dog improves mobility 2. A guide dog provides companionship 3. A guide dog necessitates personal change 4. Lifestyle changes result from guide dog ownership 5. A guide dog is a social magnet 6. Distractions inhibit the guide dog guiding 7. Ignorance regarding guide dogs 8. Source of pride to owner

Following this review of published studies, a matrix of categories and themes was developed from the data. Irrelevant comments were excluded, meanings were grouped together into categories and recurrent themes were allowed to surface. This process was considered to be complete when no more categories or themes emerged, this matrix will be presented at the start of the discussion chapters later in this thesis. Two themes were extrapolated from the data: 'Ways of Learning' and 'Nature of Learning' from patients and clients in practice settings. Within the first theme, three categories were identified: motivation; learning from patient stories/critical incidents; and facilitation of learning. Three categories were also identified within the second theme: professional ideals; professional relationships; and understanding the patients'/clients' perspectives (Table 9). These will be explored in detail in the following chapters.

Table 9: Themes and Categories Identified in the Data.

Theme	Category
Ways of learning	Motivation
	Facilitation of learning
	Patient stories/critical incidents
Nature of learning	Professional ideals
	Professional relationships
	Understanding the patient's perspective/ advocacy

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8. Methodological Rigour

Qualitative research is often criticised for its lack of rigour and validity. Koch (1994) contends that the researcher and readers should not expect perfect agreement when analysing qualitative data, but she argues that it is important that readers are able to follow the process of analysis. Appleton (1995) supports this view, suggesting that qualitative researchers can maintain their credibility by clearly considering and reporting issues of rigour within their research. Rigour in phenomenological research is a controversial topic in the literature (Crotty, 1996; Koch, 1996; Koch and Harrington, 1998; Lawler, 1998; Paley, 1998; Annells, 1999; Corben, 1999; Caelli, 2000; De Wit and Ploeg, 2006; LeVasseur, 2003; Maggs-Rapport, 2001). Several papers express concern as to the rigour of nursing research which claims to use phenomenological research approaches (Annells, 1999; Corben, 1999; Koch, 1996; Koch and Harrington, 1998; Maggs-Rapport, 2001). Indeed, Corben (1999) suggests that misunderstandings have often led to confusion about the use and application of phenomenology. To avoid this, the researcher attended a workshop led by Professor Giorgi and she accessed his original papers and other publications using his approach. As discussed in the previous chapter, the researcher hopes that her application of this research method to the specific context of this study will help to further develop the methodology.

Giorgi (1992) does not use judges or research subjects to review his data; he views every reader of the research report, with an appropriate background, as a valid critic and for this reason, he advocates including the entire interview transcripts and process of data analysis within the research report. This is not possible within the word limit of this thesis. However, extracts from the data are used verbatim in the following chapters to illustrate the themes and categories extrapolated. An entire interview transcript is also included as Appendix 6 to allow readers to follow the researcher's processes and decisions in respect of data analysis and presentation.

Giorgi (1997) argues that the precise manner of transformations gives inner validation to the study. The researcher is not allowed to make his/her own digressions or interpretations and he argues that this is designed to guarantee that the transformations express the statements of interviewees not what the researcher thinks the person said or meant. However, he does acknowledge that the precision of this method means that there are few respondents and, therefore, generalisability can only be claimed after a number of studies.

Giorgi (1989b) argues that the questions of rigour and justifiability depend on how the six steps of data analysis are applied. He argues that the issue of validity is dealt with by the researcher adopting: "the attitude of the phenomenological reduction" (Giorgi,1992, p.121). This involves the bracketing of past knowledge about the experience, to enable the researcher to enter the subject's life world and to genuinely represent the description. Bracketing

requires the researcher to recall, record and analyse his/her own experience and then to leave it aside so as not to contaminate the data (Koch,1999). Varela (1998) argues that researchers need to develop the skill to stabilise and deepen their capacity for attentive bracketing (suspending judgement) and intuition along with the skill of producing illuminating descriptions to mature the style of systematic study. Whilst acknowledging the difficulties associated with the phenomenological reduction, it was evident that this experience did enhance the researcher's ability to apply the method to the data. The researcher reflected on her own past experience, existing knowledge and beliefs, in relation to students' learning in practice settings and she attempted to put these to one side.

The major strength of using the descriptive phenomenological approach, to explore learning from patients and clients, is that it encouraged students to openly and honestly describe their own experiences. The interviews produced a large amount of data, which included students' perceptions and feelings, and which provided an insight into the meaning of their experiences of learning. The variety of descriptions given by the students indicates that learning from patients and clients during practice placements is an individual experience. However, themes emerged from the data in respect of the nature of learning and the ways in which students learned.

Criteria of rigour are needed to ensure that research methodology is systematic, accountable and high quality (Morse, Barrett, Mayan, Olson and Spiers, 2002). However, the literature advises that positivist criteria are not appropriate to judge

the rigour of qualitative research. Lincoln and Guba (1985) advocate that the following criteria are used for this purpose:

- credibility - this is considered as the qualitative equivalent to validity; that is, the information that is reported correctly represents experiences
- transferability - whether conclusions are limited to the present context or applied to other groups
- dependability - agreement in categorising findings
- confirmability - the audit and confirmation of procedures by external review

The further criterion of authenticity was later added by Guba and Lincoln (1989) and refers to fairness, ontological authenticity (enlarges one's personal constructions), educative authenticity (leads to improved understanding of the constructs of others, catalytic authenticity (stimulates action) and tactical authenticity (empowers action). These were adapted for use in nursing research by Sandelowski (1986) who proposed the four criteria of:

- Credibility
- Fittingness
- Auditablity
- Confirmability

Table 10 below demonstrates the application of these criteria to the present research study.

Table 10: Application of Criteria for Rigour to Thesis

Criterion	**Defining Characteristics**	**Thesis**
Credibility	Reading findings produces recognition of an experience Respondents would recognise experience as their own Others may recognise experience after reading report	Supervisors Giorgi does not advise returning transcripts to respondents Bracketing Include descriptions in report Reflect on own assumptions Unexpected findings
Fittingness	Study participants represent the group of which they are members Study findings fit data and other settings Readers recognise relevance of findings to their own situation	Recruitment and sampling strategy Purposive sampling Context specific Supervisors
Auditablity	Systematic decision making process – decision trail Readers can follow process and would reach same/similar conclusions Explicit rationale	Giorgi's approach to data analysis – applied rigorously Bracketing as above Practice in Master workshop and pilot study Field notes and reflective journal Audit checks by external examiners
Confirmability	Study findings not biased All above criteria fulfilled	Neutrality Freedom from bias

(Adapted from Sandelowski, 1986)

8.1 Credibility

Credibility refers to the correct representation of experiences by the researcher. The descriptive phenomenological approach of this enquiry ensured that students' perceptions were presented, in their own terms, without interpretation by the researcher. As stated earlier in the thesis, this was considered by the researcher to be one of the major advantages of the approach and she applied the data analysis processes rigorously. This involved bracketing assumptions, which was aided by previous experience of using the approach and by a reflective research diary. The following chapters use extracts from the data, in respondents' own words, to illustrate the themes and categories identified and a full transcript is included as Appendix 6. Giorgi does not advise the researcher to return the interview transcripts to the respondents, rather he advises that the transcripts should be made available to critical readers.

8.2 Fittingness

Fittingness refers to the appropriateness of the study participants, in this case the sample of nursing, midwifery and social work students that were selected. The implementation of the sampling and recruitment strategy referred to earlier in this chapter ensured that an appropriate sample was obtained. The twelve respondents were all final year, pre-qualifying students who had considerable and recent experience of the phenomenon under investigation; that is, learning

from patients and clients in practice settings. Although it is acknowledged that the findings of this study are context specific, it is anticipated that readers will recognise the relevance of these to similar practice based contexts.

8.3 Auditability

This thesis addresses auditability by the inclusion of an explicit rationale and decision trail (Annells, 1999; Koch, 1994; 1996), reflexive journaling (Koch and Harrington, 1998), and explication of the decision to use the descriptive phenomenological method (Annells, 1999; Maggs-Rapport, 2001). It is important to note that Giorgi advocates including all raw data within the research report to ensure that readers are assured that the researcher has presented the subjects' and not her own meanings. This was not possible, due to word limitations. However, extracts from the data are included, verbatim, to illustrate the process of data analysis and the presentation of themes and categories. As previously stated, an entire interview transcript is included in the appendices to this thesis to allow for external scrutiny of the data analysis process followed.

8.4 Confirmability

In the previous chapter, the researcher presented her decision to use this approach because of its focus on presenting the voices of respondents, without

interpretation or bias. Confirmability of this research is demonstrated by the rigorous application of the descriptive phenomenological method, whose purpose is to describe, rather than to interpret, experience: “a descriptive attitude implies a certain necessity demanded by saying that one describes what presents itself precisely as it presents itself, neither adding nor subtracting from it” Giorgi (1992, p.121). The inclusion of a full interview transcript provides the opportunity for external scrutiny of this process and will demonstrate achievement of the criteria of confirmability in the research process.

9. Conclusion to Chapter

This chapter has presented a detailed description of the descriptive phenomenological approach and method applied to this study. The method was selected because of its focus on the meaning of individual experience, which was considered to be directly relevant to the aim of this enquiry. This research approach has been applied previously, in a range of settings, and the studies reviewed demonstrated its effectiveness in describing respondents’ experiences. The researcher has previously used this research approach herself, to explore student nurses’ experience of learning in practice (Gidman, 2001a; 2001b), and this was considered to be the pilot study for the research reported in this thesis.

The final sample comprised twelve final year, pre-qualifying students, who had all had relevant experience of the phenomenon under investigation; that is, learning

from patients and clients in practice settings. These students were interviewed, using an open, conversational style, which elicited extensive and rich data describing their experiences. The data were analysed using Giorgi's (1989a) method of phenomenological reduction and this produced two themes, relating to the nature of learning described and the ways in which students learned. The identification of themes, rather than the essence proposed by Husserl (1970), is consistent with other published research studies which used the descriptive phenomenological approach.

Rigour in this study was demonstrated by the application of the criteria of credibility, fittingness, auditability and confirmability. The researcher argued that appropriate sampling, rigorous application of the method, previous experience of using this approach and the use of a reflective diary ensured that the criteria of credibility and fittingness were achieved. The inclusion of decision making trails and of raw data within the thesis and its appendices will allow for external scrutiny of the research approach, to ensure auditability and confirmability of the study findings.

The descriptive phenomenological research approach was used in this enquiry to explore pre-qualifying nursing, midwifery and social work students' perceptions of learning from patients and clients in practice settings. This chapter has described, in detail, the method of data analysis used within this study, using extracts from the data to illustrate the process. Data analysis involved rigorous application of the six stages of the descriptive phenomenological method

proposed by Giorgi (1989a; 2000c). The researcher was committed to the rigour of the research enquiry and this was facilitated by previous experience of using the approach (Gidman, 2001a; 2001b; Giorgi, 2000c), keeping a reflective diary, and through regular supervision sessions. It also anticipated that the inclusion of raw data within the thesis and of a complete interview transcript (Appendix 6) will enable external scrutiny, auditability and confirmability of the data.

Although the method aims to identify the essence of a phenomenon, this enquiry, in keeping with the other published research studies, resulted in the identification of themes and categories. The data obtained in this study were extensive and were, therefore, considered to be adequate; they provided rich descriptions of the phenomenon under investigation and were also, therefore, considered appropriate to answer the research questions (Morse, 1994).

Throughout the development of this thesis, the researcher adopted a reflexive approach to the implementation of the research approach, by means of a reflective diary and regular supervision. She acknowledges that the descriptive phenomenological research approach has limitations when applied in practice, particularly in relation to the concept of bracketing within the process of phenomenological reduction.

Giorgi (1989a) contends that data analysis, using phenomenonological reduction, is a scientific process which enables the researcher to maintain an objective stance. This is in contrast to the constructivist philosophy which underpins

phenomenology as a research approach and which was considered by the researcher to be the most relevant to this study. The process of phenomenological reduction involves the researcher bracketing prior knowledge and experience. The application of the approach within this research study confirmed the difficulties inherent in this process (Koch, 1999; Le Vasseur, 2003). The researcher used her previous experience of the research method, reflective diary and supervision sessions to further develop her skills in bracketing. Whilst it is acknowledged that this remains an imperfect process, the researcher concludes that the aim of bracketing prior knowledge and experience is worthwhile and that it enabled respondents' views to be presented without bias. This is demonstrated in the later chapters of this thesis by means of the unexpected findings which emerged from the data.

Complexity theory has been influential in the development of this thesis to date and was applied to the conclusions of the literature reviewed in earlier chapters. Although it was never the intention to use complexity theory as the theoretical framework underpinning this research study, it is evident that its main concepts are in keeping with the phenomenological approach adopted. Both complexity theory and the phenomenological approach provide alternatives to traditional positivist approaches to research in health and social care. The holistic approach of this research study enabled participants to present their own perceptions, in their own words, and to explore the ontological and epistemological aspects of learning. The complexity of the context of this study was evident, in that the practice placements accessed by students were within

dynamic and unpredictable organisations. These displayed the features of complex adaptive systems with a range of agents, relationships and networks.

The researcher, therefore, continued to reflect on complexity theory in relation to the aim of the research study – to explore pre-qualifying nursing, midwifery and social work students' perceptions of learning from patients and clients in practice settings. She concluded that this was relevant to this aim, because of its holistic focus, its recognition of the complexity of learning and the acknowledgement of both the ontological and epistemological aspects of learning.

Chapter 6: Ways of Learning

1. Introduction

This is the first of two chapters which present the findings of the study. It provides a comprehensive discussion of the data relating to the 'Ways of Learning', with reference to the literature reviewed earlier in this thesis. Although the themes are presented and discussed in two separate chapters, complexity theory's concept of simultaneity (Davis, 2008) is relevant to this thesis because it is evident that the data in the two themes are inextricably linked. Within this first theme, three categories were identified: motivation; learning from patient stories/critical incidents; and facilitation of learning (Diagram 2).

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Table 11 below illustrates the mapping exercise for the first theme 'Ways of Learning', which will be discussed in detail below. Meaning units one and two of each transcript were not included in this mapping exercise. In all interviews, the first meaning unit related to consent to the interview and the right to withdraw any information. This did occur in Interview Three, in which the respondent described a critical incident relating to a neonatal death and asked that details of the failed resuscitation attempts were not transcribed.

The second meaning unit in all cases referred to the respondents' practice experience to date. This was in response to an introductory 'safe' question intended to help students to relax and to set the data in the context of their

programmes. The nursing students (R 1, R2, R4, R5, R8 and R9) had experienced a wide range of short placements in acute and primary care settings and in relation to mental health, learning disability and child specialist services. The midwifery students (R.3, R6 and R7) had also undertaken a range of short placements, but their experience had been primarily in the community and in ante-natal, post-natal and labour wards, with some acute adult care. In contrast, social work students (R10, R11 and R12) described two long placements, one in a statutory and one in a non-statutory organisation. It was interesting to note that all respondents became more relaxed as the interview progressed and this is reflected in the data.

There were only three meaning units, across all the interview transcripts, which did not fit into the categories identified:

- R8 acknowledges the cost of the secure learning disability unit in which she is currently placed (R8, MU 15)

- R10 describes how to complete social work referrals (R10, MU 6; MU9).

This chapter will now continue with a discussion of the categories of: motivation; patient stories/critical incidents; and facilitation of learning.

Diagram 2: Theme 1 - Ways of Learning

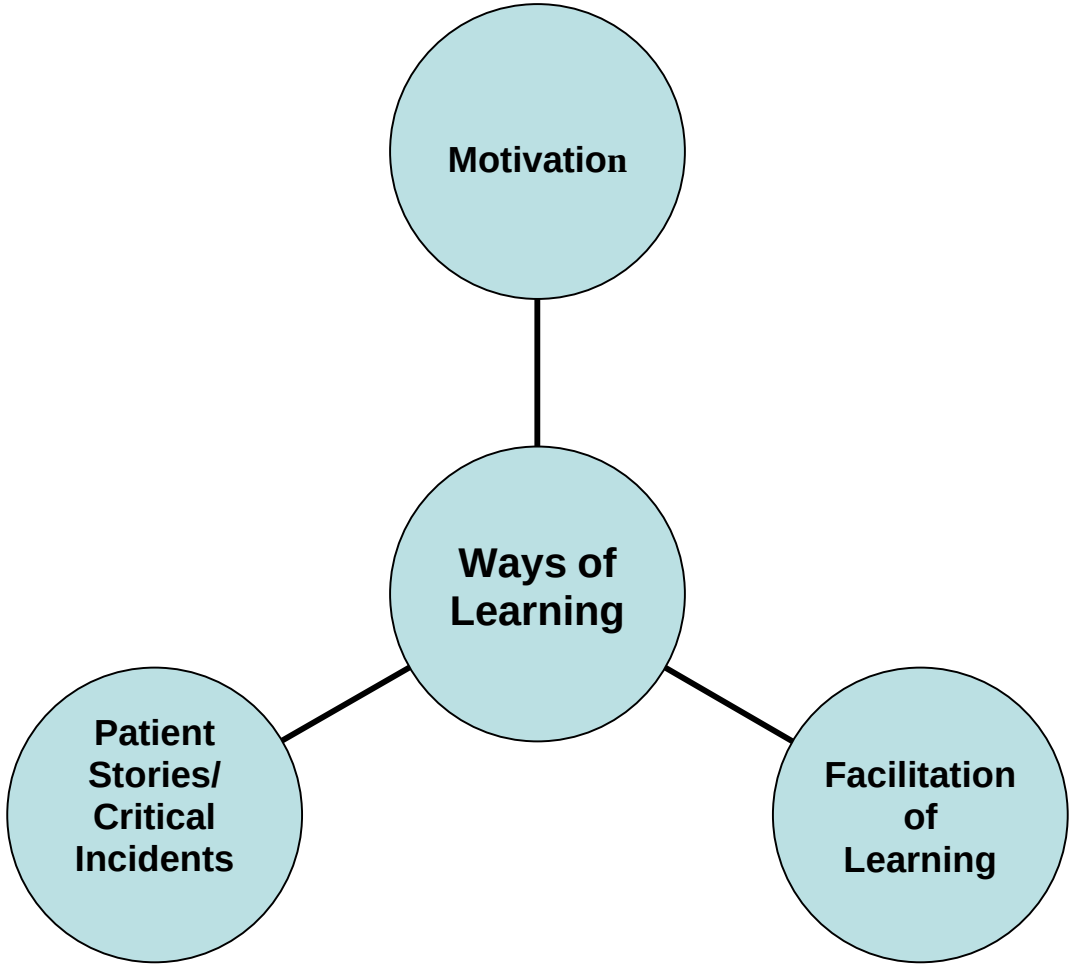


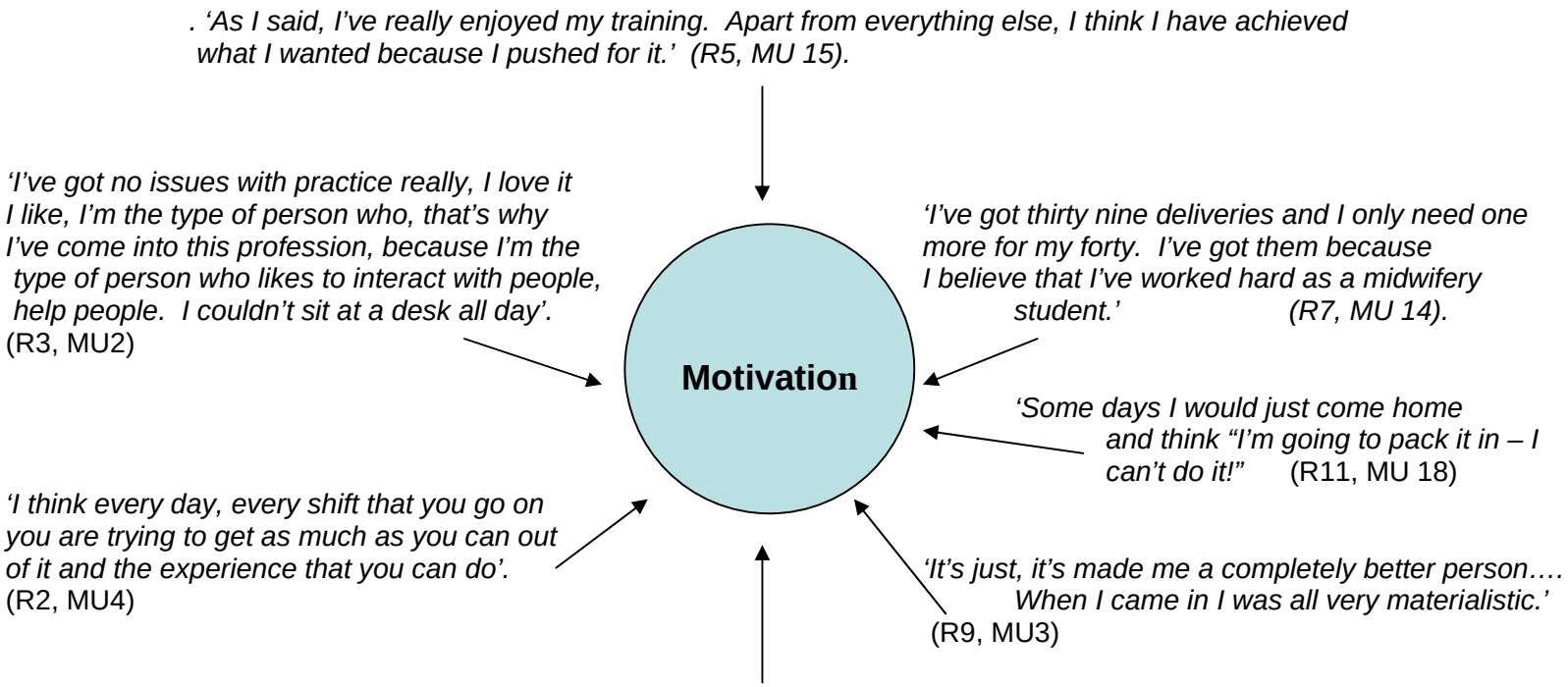
Table 11 - Theme 1: Ways of Learning: Table to Demonstrate Categories Extrapolated from the Data

Theme	Category	Interview/meaning unit
1. Ways of Learning	1.1 Motivation	1.3, 1.6, 2.3, 2.4, 3.2, 3.3, 3.6, 3.7, 4.2, 4.14, 5.11, 5.12, 5.13, 5.14, 5.15, 6.11, 6.14, 7.4, 7.9, 7.11, 7.13, 7.14, 7.16, 7.17, 7.18, 8.7, 8.8, 8.9, 8.10, 8.19, 8.22, 8.25, 8.27, 9.3, 9.11, 9.17, 10.17, 11.2, 11.4, 11.7, 11.12, 11.18, 12.2
	1.2 Patient stories/ Critical incidents	1.5, 1.7, 1.8, 1.13, 1.14, 2.7, 2.12, 3.11, 3.12, 4.4, 4.12, 4.13, 5.5, 5.7, 5.8, 6.12, 6.13, 6.14, 7.7, 7.8, 7.12, 7.15, 8.11, 8.24, 8.26, 9.4, 9.5, 9.7, 9.8, 9.9, 9.10, 9.16, 10.11, 10.12, 10.13, 11.11, 12.4, 12.8
	1.3 Facilitation of learning	1.3, 1.6, 1.9, 1.10, 1.11,1.16, 1.18, 2.3, 2.4, 2.7, 2.8, 2.11, 2.14, 2.15, 2.16, 2.17, 3.4, 3.5, 3.8, 3.9, 3.10, 3.17, 4.2, 4.8, 4.9, 4.11, 4.14, 5.4, 5.9, 5.10, 6.7, 6.8, 6.9, 6.16, 7.3, 7.5, 7.10, 8.3, 8.4, 8.6, 8.10, 8.11, 8.19, 8.28, 9.7, 9.9, 9.14, 9.15, 10.4, 10.5, 10.10, 10.15, 11.3, 11.4, 11.5, 11.6, 11.11, 11.13, 11.15, 11.16, 11.19, 12.3, 12.8, 12.11, 12.12, 12.13, 12.14, 12.15, 12.17, 12.18

2. Motivation

The data provided evidence that all respondents were motivated to learn, that they recognised their responsibilities for their own learning, and that they demonstrated considerable commitment to both the programme of study and to their chosen professions (as illustrated by Diagram 3 below). It was also evident that this motivation enabled the respondents to access a range of unplanned learning opportunities without the involvement of their mentors or practice teachers. This category will be discussed in relation to respondents' reasons for commencing their programmes; commitment to the programmes despite the challenges; responsibility for own learning; and personal satisfaction.

Diagram 3: Examples from the Data to Illustrate Category 1.1 - Motivation



'On other placements they've been that short of staff that we've actually been counted in with the numbers, where I am now they're actually, you know you are supernumerary and they treat you as supernumerary and you are actually allowed to work with staff nurse.' (R1, MU3)

2.1 Reasons for Commencing the Programme

Several of the respondents acknowledged the role of their own personalities in their decision to commence the programme. For example:

> *'I've got no issues with practice really, I love it. I like, I'm the type of person who, that's why I've come into this profession, because I'm the type of person who likes to interact with people, help people. I couldn't sit at a desk all day'.* (R3, MU2)

The data also indicate that the respondents' own, or their relatives', experience of health and social care services had influenced their choice of profession. For example, R8 recognises the impact of her son's mental health problems on her decision to enter learning disability nursing:

> *'Yes, I felt that was why I couldn't do mental health. I think it was too close to me…..'.* (R8, MU21)

R7 directly attributes her decision to start the midwifery programme to her own experience of childbirth:

> *'I had my children in this hospital, so that's why I went into it anyway.*

My second little girl was prem - thirty one weeks - and I'm sort of repaying my debt to society and it's a job that I love and I'll love it forever. I never, ever think "oh I've got to go to work" because I love coming in – I really do'. (R7, MU18)

2.2 Commitment Despite Challenges

All respondents demonstrated a high level of commitment, and the data indicated that in many cases they had encountered a range of difficulties which had presented barriers, not just to their learning, but to their ability to complete the programme.

R12 explains that at the start of her social work placements she made a conscious effort to look interested in the work of the team:

'Erm, I suppose when you first start off at a placement, the first few days are kind of settling in, and watching what's going there and you know, bits of conversation between people and usually given erm, policies and guidelines about the organisation and you try to look interested in those……. A few days settling in period, I think that's the hardest time really, because you want to learn, to get started, but because you haven't had the experience you're kind of "watch this", you know, so, yes but I think you learn a lot

really from listening to people on the telephones, talking about the cases and …' (R12, MU2)

Respondents recognised that their positive attitudes were integral to their learning, for example:

'To be honest, I've gone to all placements with an open mind…… Other students who have been on there and said how things have gone and try to ignore that and just see what happens and I mean I'm fairly motivated and to get on and learn as much as I can from that placement for the time I'm on there. I think every day, every shift that you go on – you are trying to get as much as you can out of it and the experience that you can do'. (R2, MU4)

This is supported by a response from R3, who recognised her own development throughout her midwifery programme:

'Erm, college-wise it's quite bombarding the amount of information you get. And I think its just seeing yourself progress and realise that you can interact with women and you can answer their questions because when you put your gained knowledge and experience and, you know, I'm not afraid if some woman asks me a question well I

don't know that I'll go and find out for you, you just learn through experience really. That's the nature of the job'. (R3, MU3)

The majority of respondents describe competing priorities, including the needs of partners, children, placements, completing assignments and additional part time jobs. Several respondents perceived that the workload was too great, R7 describes this as *'overwhelming'* , R10 found parts of the social work programme '*really stressful'* and R11 uses emotive terms such as: *'extreme' 'intense*' and *'it's a nightmare'.* She explains that during her social work placements:

'Some days I would just come home and think "I'm going to pack it in – I can't do it!"'. (R11, MU18)

This is supported by R7, who describes issues relating to her midwifery programme:

'*Just the workload, the college workload, the workload here, all the different placements we go on. I've got two young children, I've got a partner, I've got a house to run. I work in a nursing home at the weekends so ……'.* (R7, MU 15)

The difficulties reported in this study are consistent with the literature relating to student attrition. As discussed in chapter one, this is a major concern within professional programmes, because it has major financial implications for

institutions and it leads to a shortfall for the profession. The issue of student retention is a high priority for universities internationally (Tait, 2004; Yorke, 2004; Yorke and Longden, 2004; Zepke and Leach, 2005). Recent studies, many in professionally focused programmes, (Brown and Edelmann, 2000; Jeffreys, 2001; Jeffreys, 2007; Nora, Cabrera, Hegedom and Pascarella, 1996; Poorman, Webb and Mastorovich, 2002) have addressed students' experiences of learning and possible reasons for leaving a programme and identified several contributory factors. Included amongst these were academic, environmental and social integration issues, namely: family responsibility; financial concerns; feelings of distance from faculty and staff; stress associated with feelings of being academically unprepared; minimal social integration; and achievement motivation. A recent study, carried out within the researcher's own organisation, examined the causes of attrition in pre-qualifying nursing, midwifery and social work programmes (McIntosh, Gidman and Melling, 2008). This was a large scale study using questionnaire and focus groups and included four hundred and fifty respondents. The findings support the published studies and the responses discussed above, indicating that students perceived that workload associated with the programme and competing priorities were barriers to their learning.

The literature tends to focus on attrition, with studies exploring students' reasons for leaving programmes. However, Barnett (2007) suggests that it is, in reality, extraordinary that so many individuals persist with the challenges of their education programmes over a number of years. He argues that commitment is central to higher education and that it is not the reasons that students leave

higher education which are important, but rather the fact that students achieve despite the many challenges. He also proposes that the will to learn is the foundational disposition of students and without this learning is not possible. This view is consistent with the findings of this study. Respondents were near the end of their programmes and many described their experiences of succeeding despite the many challenges discussed above.

In addition to the issues of workload, several respondents also reported difficulties associated with their placements in respect of supernumerary status and staffing problems:

> *'On other placements they've been that short of staff that we've actually been counted in with the numbers, where I am now they're actually, you know you are supernumerary and they treat you as supernumerary and you are actually allowed to work with staff nurse'*. (R1, MU3)

> *'Because I think you can say whoa, hang on. I mean I haven't got a problem at all doing hands on care at all. But when, because on our course we're supernumerary and in a lot of areas the feedback is that you're not classed as supernumerary. Erm, but I don't mind being included in the numbers as long as there's enough people to carry you at some point you take time out to observe something or something like that. You don't want to be feeling that you're leaving*

somebody else to carry your workload, that's not the idea of being supernumerary……..So and I think as a mature student you've got that bumph, I mean some of the younger one's have but I think I'm able to say – "hang on a minute I am supernumerary". And I do have to say it on many occasions. Because the old trainees they weren't supernumerary in their third year…..I think its how you present it really. Like I know it caused mayhem once, when one student said I'm only here, I haven't come to do any work, I'm only here to – she got the wrong concept of supernumerary I think, yes'.

(R8, MU3)

As discussed in chapter two, practice learning is central to professional education and it is a requirement that nursing, midwifery and social work students spend part of their pre-qualifying programmes learning in practice settings (GSCC, 2002b; NMC, 2004a; 2004b). Greater emphasis on practice experience within curricula, and increased student numbers, led to pressure on placement capacity, with corresponding concerns about the quality and quantity of placements (Brennan and Hutt, 2001; Collins and Turunen, 2006; Conway and MacMillan, 2000; Furness and Gilligan, 2004;). The data in this study support these concerns and illustrate some of the challenges faced by students when accessing learning opportunities. This supports the contention that practice settings are complex environments and suggests that the concept of complex adaptive systems is of relevance to the data in this study. This will be further explored in the final chapter of this thesis.

2.3 Taking Responsibility for Own Learning

It was evident that respondents were aware of the difficulties associated with practice placements and that they were realistic in their expectations. For example, R4 explains how she was able to use her own experience to challenge the unrealistic expectations of a more junior student nurse:

> *'Well - sometimes for students it's difficult to get the experience you require but I think part of your learning process to be able to distinguish, and I think, I'm with a first year student at the moment and she's been panicking. She's been saying "I need to do this, I need to do that, blah de blah". And I took her aside and I said "look I think you're trying, you're trying to run before you can walk" and after I'd talked to her for a while I think she realised. And I thought I felt like that in my first year. I think you want to learn everything to begin with and you realise it does come even though you can't see that it is. But sometimes the wards are very busy, it's very difficult to work with your mentor and you do feel that you're not learning what you should, you're not having the experiences that you should, and participating in certain things that you should be. As you come to the end of the training you realise you have done'.* (R4, MU2)

It was also apparent that respondents were motivated to learn and that they actively sought learning opportunities and took responsibility for their own learning. This is illustrated by responses from R5, R7 and R11:

> *'As I said, I've really enjoyed my training. Apart from everything else, I think I have achieved what I wanted because I pushed for it.'*
>
> (R5, MU 15)

> *'I've got thirty nine deliveries and I only need one more for my forty. I've got them because I believe that I've worked hard as a midwifery student'.* (R7, MU 14)

> *'I don't know, maybe it's because, everybody said I was always so enthusiastic…..Always laughing and joking and smiling, and erm, I was approachable, but I think I am more of a people person anyway.*
>
> (R11, MU12)

This is consistent with the andragogical approach to learning, as discussed in chapter one, which has contributed extensively to nursing, midwifery and social work education (Dick et al*.,* 2002; Purdy, 1997a; 1997b). Adult learning theory has its origins in the model of andragogy, which was proposed by Knowles (1990) in which he identifies differences between the education of adults and that of children. Knowles proposes that adults need to be self-directed in their learning, that they bring past experience to their learning, value experiential learning, prefer immediacy of application and are problem centred in their

approach to learning. Problem-based learning was identified, in chapter one, as a valuable strategy to promote the andragogical approach to learning in professional education programmes (Gidman and Mannix, 2006). Although none of the students in this study referred to problem-based learning, their responses provide considerable evidence that these respondents were self-directed in their learning and many of the experiences reported were problem focused.

2.4 Personal Satisfaction

All respondents reported that they gained personal satisfaction from their experiences with patients:

> *'Only being, the thing I find really positive is when they, when they're leaving and they're being discharged and they make a point of singling you out, wherever you are and just come and say thank you for all the care. That's all you need. That makes my job worthwhile just to say thank you. Not that they single me out personally but I have had patients come to see me … Yes, yes. I mean you have, they just come past the desk and they wave and they don't care who's there, but when they actually say where's R1 working and then they come and find you'.* (R1, MU 15)

Indeed, R4 and R7 both use the term *'buzz'* to describe their satisfaction following positive experiences with patients.

Several respondents reflected on the impact of their experiences during the programmes on their own lives and on their conceptual perspectives in life, not just in the profession. For example, R9 described the programme as life changing, she gave up a full-time, well paid job to commence child nursing and is now less materialistic and appreciates her own life:

> *'Well, It helped me a lot because I just think a lot of things I get concerned about, this little girl has got all this to worry about, and I'm getting stressed that I broke a nail or you know, something! It's just, it's made me a completely better person…..When I came in I was all very materialistic. I was like this is important because I worked before I came here, I had a full time job so I left a full time job, so I was used to a full time wage and things. And erm, clothes-wise and things I had to have the latest of everything. And I wouldn't ever be seen in any high street shops, I wanted to be, you know shopping in Manchester. And now my favourite shop is George at Asda (laughs) because, one I can't afford it and two, there's much more important things going on to worry about'.* (R9, MU 3)

This response is consistent with Barnett's (2007) philosophy of higher education, in which he contends that students' being and experience are inextricably linked

and that over the period of his/her course the student will change his/her conceptual perspective on life: “In committing herself the student breaks her own mould. She fashions herself into a new person. She places herself where she was not previously” (p.50). Barnett’s philosophical stance will be discussed in more detail in chapter nine, with reference to theories of transformational learning and of complexity.

It is evident from the data comprising this category that the respondents were all motivated to learn during their practice placements. They recognised that they needed to exhibit a positive attitude to their colleagues, and to be willing to work and learn. They were all aware of their own progression throughout their programmes and were able to take responsibility for accessing learning opportunities. It was also apparent that respondents succeeded throughout their programmes, despite the many challenges they encountered in terms of workload, family commitments and placement difficulties. The data in this category suggests that students recognised the value of learning to increase their status with their practice colleagues and that they used their knowledge as capital to enable their own progression.

3. Learning from Patient Stories/Critical Incidents

All respondents described experiences of learning from patient stories and/or critical incidents, examples of which are illustrated in Diagram 4 below.

Diagram 4: Examples from the Data to Illustrate Category 1.2 - Patient Stories/Critical Incidents

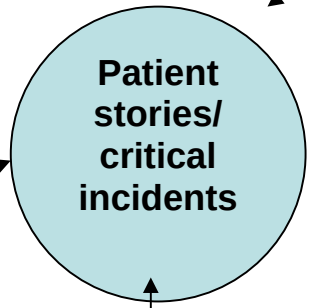
'…a member in her family, she has got two young children, she was actually diagnosed with cancer while I was there'. (R9, MU 4)

' they turned the machine off and we came in and said all our goodbyes'. (R1, MU 14)

'Just recently I took over care of a lady who unfortunately the baby died'. (R3, MU 11).

' Erm, she was quite mentally ill, and you know, just her look – you could see that she was mentally ill and erm, I didn't want that to get in the way'. (R12, MU7)

'I have found patients fascinating to……. their own stories….their own experiences and how they deal with their illnesses themselves'. (R2, MU 12)



'I had time to talk to the women and understand, talk about their birth stories, not the birth stories I was involved in, other birth stories and what they felt'. (R6, MU 12)

'Not from that no, because I couldn't take much from that experience because it was too overwhelming. I never took that much in '. (R6, MU 14)

For the purpose of presenting the findings of this study, patient stories are considered to be experiences where the students learned from listening to the patient's/clients' story in practice, rather than classroom environments. Critical incidents are considered as the experiences which had a major impact on the respondent at the time and which caused them to question their own practice or that of others.

The majority of both patient stories and critical incidents related to professional relationships and the focus of these are summarised in Table 12 below. It is apparent from this Table that respondents reported a wide range of experiences, some very distressing. For example, one respondent provides an extensive description of her experience of caring for parents following the death of their baby and a subsequent post-mortem. Many of the experiences related to the relationship between professionals and patients; for example, inappropriate communication when breaking bad news and judgemental attitudes towards patients. Respondents describe their learning from these experiences in terms of recognising both effective and ineffective professional relationships. Although the data provided little evidence of formal reflection on these experiences, it is apparent that they had a major influence on the respondents and that they could identify learning as a result of these. This important focus on professional relationships will be explored in the following chapter in relation to the second theme which emerged from the data; that is, the nature of learning. This category will be discussed in relation to critical incidents in students' personal lives; critical incidents during practice placements and patient stories.

Table 12: Table to Demonstrate the Focus of Patient Stories/Critical Incidents Within the Data

Respondent	Nature of Experience
1	A patient was very rude to a member of staff who was pregnant
1	Her father dying in intensive care
1	Nurses were unprofessional and judgemental in their dealings with a patient who was alcoholic.
2	Assisting a district nurse to care for a terminally ill patient and her family.
2	Listening to a range of patients' stories about their experiences of illness
3	Caring for a woman whose baby died unexpectedly soon after birth.
4	Caring for a woman who had communication problems following a sub–arachnoid haemorhage
4	Colleagues dealing inappropriately with a man who was suffering from dementia
4	Colleagues speaking inappropriately when delegating care
4	Caring for a young woman who was terminally ill
5	Caring for a man admitted to hospital in a very unkempt state
5	Follow through the care of a patient following a stroke
5	Follow through the care of a patient admitted for a hip replacement
6	Serious incident on labour ward where the baby was in distress during the birth.
6	Listening to womens' birth stories
7	Caring for a woman in labour whose partner was not supportive
7	Distressing experience where a woman screamed during an episiotomy
7	Experiences of caring for women during deliveries
7	Caring for a woman who was having difficulty breastfeeding
8	Caring for an elderly woman who refused treatment for breast cancer
8	Son's experience of mental health services
8	Support provided in community settings over Christmas period
9	Advocating for a child with a broken arm
9	Caring for parents of a child undergoing a tonsillectomy
9	Accompanying her cousin when she was diagnosed with cancer
9	An incident where a child went into respiratory arrest on the ward.
10	Caring for a woman with dementia who was referred to the social work team
11	Involvement in a child protection case
12	Organising community support for a woman with mental health problems
12	Assessment of a man in hospital with mental health problems

3.1 Critical Incidents in Students' Personal Lives

Several respondents related critical incidents which had occurred outside of their professional programmes, for example R1 described the distressing experience of her father's death on an intensive care unit:

> *' they turned the machine off and we came in and said all our goodbyes and ……. I said "excuse me but what are you doing? What are you doing now?" and she said "Oh it's alright I'll leave his pain relief going" I said to her "you're turning him off now are you?" and she said "oh yes, yes." I thought that was really awful… You know, I say that's from a personal point of view. I thought that was really, really awful. Because not only did two of my sisters not wish to be there at the time and then they were sort of forced into the position of being there…..No, it just makes me more aware, always explain what you're doing before you do it. I know we'd sort of given consent to that by saying yes do it, but…… You know, my youngest sister, he was still with us and still breathing. Whereas I knew that it was only the ventilator and the drugs that were keeping, you know giving the illusion that he was still alive. She didn't understand that'.* *(R1, MU14)*

R9 reports her experience of supporting her cousin, who had been diagnosed with cancer and she recognises that this influenced her own communication with patients:

> *'Erm, when I was down, I think …….at one time, when I was down in Southampton, I lived with my cousin who was the same age and me. And a member in her family, she has got two young children, she was actually diagnosed with cancer while I was there. Erm, I saw it on the flip side and that has completely, that's changed me as well, because you come out with a word like canula people don't know what it means. And my cousin was really scared, "what on earth is a canula?" And she's a twenty six year old female, you know, never heard of it. So the way I speak to my patients I always sometimes look at it, I sometimes feel doctors need to take a step back and think "how would I feel if this was happening to me?" Because, and like the other day, erm, when a woman was told she had a cancer and the doctor just came out and said "you've got cancer" Didn't prepare her for it or anything. I just thought "wow". And then, the other day, I saw it on the ward where the doctor just went in to the patient, the child's got an abnormal size head, she was going down for a scan, and walked out and that was it. You can imagine the woman was on the ceiling, just like "Oh!"* (R9, MU 4)

Respondents R1 and R9 were both aware of their learning from these experiences and when questioned about the nature of this learning, responded in terms of communication and relationships:

> *'But that was just bad, to me, it was just bad communication.'* (R1, MU14)

> *'And I just think, sometimes the doctors need to take a step back. And not just doctors, some nurses and think how they would feel if they got told that and they're not medically trained and they don't know, you know, we are doing it for the child's benefit, thing, but it's just….'.* (R9, MU 4)

It is interesting to note that these responses were all from nursing students. No examples of critical incidents from students' personal lives were identified in the transcripts from the midwifery or social work students. However, due to the small sample size of the study, no conclusions will be drawn in relation to this finding.

3.2 Critical Incidents During Practice Placements

R3, a midwifery student, recognised her learning following a critical incident, she described her experience on a labour ward involving the care of a woman whose baby had died unexpectedly:

'Yes. Just recently I took over care of a lady who unfortunately the baby died. And the baby died and we took over her care. So I had no rapport with this woman, so when she was informed that her baby had unfortunately didn't survive she's got two, a student and a new midwife that she'd never met before trying to offer condolences and support. And she didn't have any trust or rapport. That was very difficult…….Erm, it was just. I'd looked after this lady over a three day period and gradually over the three days we built a fantastic relationship with each other and very supportive with each other. For both it was a two way relationship, interaction really. But initially when we took over the care obviously the parents were, just …Erm, the baby, they'd had, they'd had various scans and tests done and there was, they thought there was something wrong with the baby but not, they didn't realise it would be incompatible with life. They thought something could be done to help this baby but it was incompatible with life. It was a complete shock, it wasn't detected. So the cause, the baby hadn't survived, they were unaware of, they thought it was just a syndrome but it wasn't. So as I say when I took over the care it was just literally saying that we're here for her and if there was anything they wanted to ask'. (R3, MU11)

R3 recognises and values the role of the woman in that learning:

'My learning was how the woman helped me through it. You know, because I'm going to be in this woman's memory for the rest of her life, but she's also going to be in mine because she helped me deal with a very difficult situation'. (R3, MU 12)

In a very different context, R12 relates an experience in which a woman with mental health problems was referred to her social work team following discharge from a psychiatric hospital. The woman had previously refused any input from social workers:

'So I did find it really difficult at first, I thought well the worst I can do is phone her up and offer, explain who I am, why I was ringing and what I could do, erm, and just see how she felt about it really. So I did that, I telephoned her, and erm, explained, you know, that I was a student, that this referral had been passed over to me and erm, you know, and I could her an assessment to see if there was anything we could do to kind of help her following her discharge. She listened to me and I said, you know - "I am aware that you've refused social workers erm, help before, but the decision is completely yours". She said "yes come over".....So I was really because it's like – I've done things properly – she's accepted me ....I think, first of all I try to get to know a person, so I'm not going in with any, sort of, preconceived thoughts or ideas. Erm, she was quite mentally ill, and you know, just her look – you could see that

she was mentally ill and erm, I didn't want that to get in the way. So, I do try very hard to let the person come out, if you like and so it was spending the first few times just listening, just basically listening and for me to try to get an understanding of her perspective on things. Which she did very well, she had tremendous insight into her own experiences, into the way other people experience her and either understand her or not …..You know, the fear that people have. She talked about all that really openly, it was just so, I don't know, I saw her as - she was a person'. (R12, MU7)

R12 recognised the need to listen to the woman and to allow time to understand her perspective of the situation, in order to be accepted by her. She also gained considerable insight into the woman's understanding of her own illness:

'Erm, I think her understanding, her level of understanding…….and while there may be periods when she might not be rational, she still knows what's going on and she'll remember it when she comes out of that stage….."I know I've got to have a wash but I can do that when I'm out of my depression or my manic stage, it might take three weeks but I can wash then – what difference does it make?" '

(R12, MU8)

Although the data indicates that respondents recognised their learning following a range of experiences, R6 found the experience of a medical emergency, during labour, so stressful that she did not perceive that she was able to learn from it:

> *'Not from that no, because I couldn't take much from that experience because it was too overwhelming. I never took that much in. It was like I was the woman, it all just muffled around me, I couldn't take in what was going on. So no, I don't think I learned anything from that experience'.* (R6, MU 14)

Some of these critical incidents caused great anxiety for the respondents involved and support was not always available to debrief them. It is evident that, for the majority of these experiences, there was no formal facilitation of learning by mentors or practice teachers.

These critical incidents provide examples of learning in the zone of complexity, where students felt anxious but learned from difficult situations, but also of experiences of being in the zone of chaos and of not learning due to excessive levels of anxiety (Stacey, 2001). An example of a critical incident relating to the nature of a professional relationship is included in the next category (R12, MU15). This demonstrates effective facilitation by a social work practice teacher, whose support for the student created a zone of complexity rather than chaos.

As discussed in chapter one, critical incident analysis was developed originally to minimise risk and improve safety in the aviation industry (Flanagan, 1954) and later within anaesthetic practice (Craig and Wilson, 1981). However, since then it has been used widely within health, social work and education, using reflection as a means of promoting learning from experience (Chesney, 1996; Lister and Crisp 2007; Parker, Webb and D'Souza, 1995; Tripp, 1993). Most of the literature relating to the use of critical incidents, as educational tools, advises that they need to be written accounts which are then analysed with the support of a more experienced professional.

R9 is the only respondent to describe formal reflection on critical incidents, which were organised by the ward sister on a particular ward. She found these helped her to explore her feelings around difficult experiences and positive events, but did not report any strategies to facilitate her learning.

> *'You do, because it makes you realise because, sometimes you are in pairs and sometimes you are in a group talking about experience, sort of thing. It's quite nice to hear how others are feeling and feeling the same as you, you're not going to be well I'm doing it wrong, have I got too close?'* *(R9, MU9)*

Critical incidents were traditionally considered to relate to problematic or puzzling events, which is consistent with Dewey's (1938) notion of learning from perplexity and Schon's (1987; 1991) contention that reflection arises from uncertainty.

However, more recently it has been argued that critical incident analysis should be applied more widely to routine practice, in order to challenge existing discourses and to explore the complexity of practice experience to develop new understandings (Francis, 2004; Tripp, 1993). This interpretation of critical incidents relates to respondents' descriptions of patient stories, which involved experiences of listening to patients and clients and of following through their care.

2.3 Patient Stories

Several respondents referred to their learning from patient stories, although only two of them refer to these experiences directly by this term:

> *'I had time to talk to the women and understand, talk about their birth stories, not the birth stories I was involved in, other birth stories and what they felt, what they felt when everybody started talking about ventous or section, or whatever. And I've made a mental note of that, so when I'm in that situation, I'm thinking about how she feels and I'm confident through the knowledge that I've gained upstairs that I can make her feel better. I think. I think I make them feel better'.*
>
> (R6, MU 12)

Birth stories are recognised in midwifery education as a valuable tool to help women to understand their experiences of childbirth, and more recently to promote learning for students (Farley and Widmann, 2001). Patient stories were reported by several other respondents and the concept appears to be applicable to other students in health and social care. However, there was little published work to support this relating to nursing or social work students. Examples of learning from patient stories were described by the following nursing students:

> *'I think, you know, I mean, some of, I have found patients fascinating to, you know, again their own stories, erm…their own experiences and how they deal with their illnesses themselves'.* (R2, MU 12)

> *'You learn a lot from patients around their conditions. They know far more about them than what I do as a student….from the patient, yes. Better from the patient'.* (R1, MU4)

> *'I had an assignment on stroke and I had the opportunity to follow a patient and he had endoscopy and broncoscopy and it was learning how to prevent the stroke then how to make speech better'.* (R5, MU7)

> *'So I took him to theatre and I managed to get them to let me watch. How that happened and everything, what they do. And I went in recovery with him, come back and just relate to him and explain*

what happened'. (R5, MU8)

It has been suggested that professionals and patients have different types of stories, with medical stories valuing objective and rational perspectives and patients and their families valuing subjective and emotional perspectives (Frank, 1997; Hallenbeck, 2003). Patient stories have been recommended within medical education as a valuable form of case knowledge (Cox, 2001). The data in this study provide a number of examples of experiences from which students learned from the subjective and emotional perspectives as presented by the patients themselves. Whilst there is recognition of the value of this for patients, the educational value to students has only recently been recognised in health and social care education (Moon and Fowler, 2008).

The data, within this category, demonstrated that all respondents had experienced a range of patient stories and/or critical incidents throughout their practice placements. It was surprising that, in the majority of cases, respondents did not refer directly to reflection in relation to these incidents, despite its prominence as an explicit learning and teaching strategy within their programmes. The literature suggests that reflection on critical incidents should be facilitated by an experienced professional. Respondents in this study articulated learning from a range of experiences and it is evident that, despite the fact that they were not actively facilitated, these were valuable learning experiences for students.

The knowledge gained from patient stories and critical incidents relates largely to relationships and to the nature of professional practice. This is consistent with the notion of alternative forms of knowledge advocated for health education to complement the traditional positivist perspective of knowledge (Cooper, Braye and Geyer, 2004; Greenhalgh, 1999; Greenhalgh and Collard, 2003).

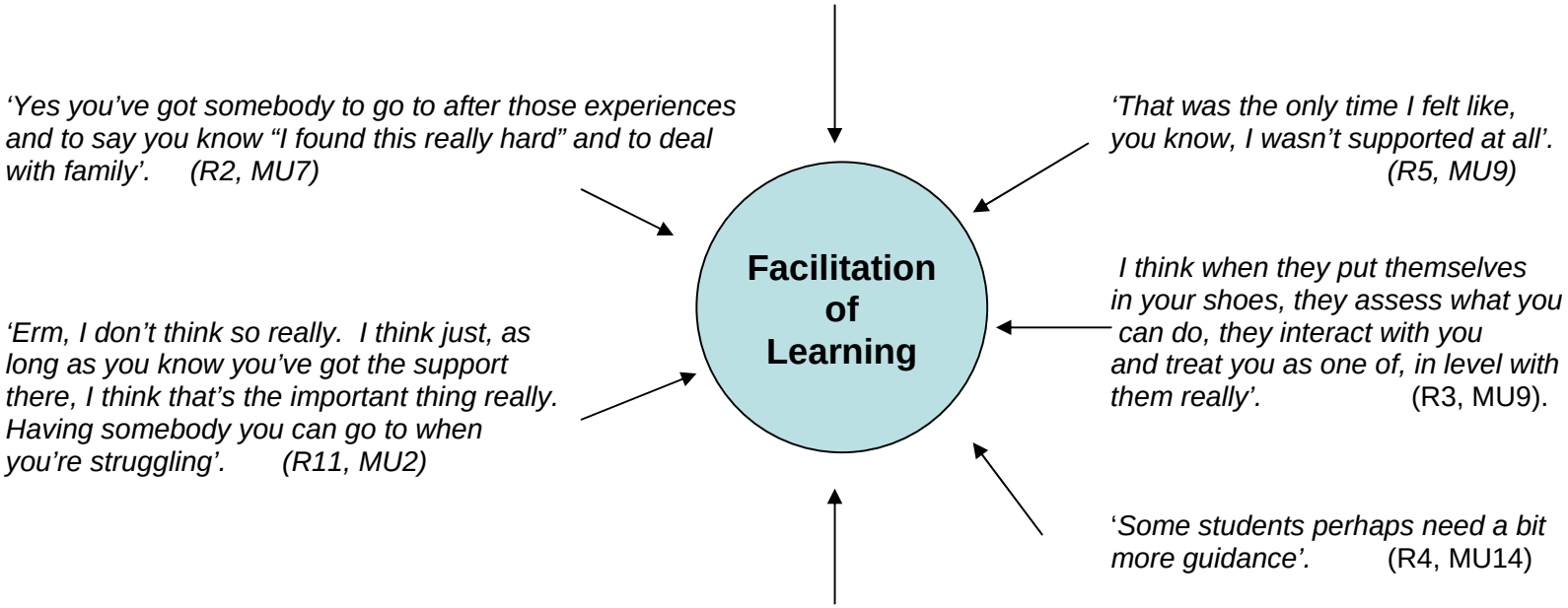
4. Facilitation of Learning

This section will explore the data in relation to the third category within the theme; that is, the facilitation of learning. The data in this category includes respondents' explanations of the range of systems in place to support them in practice, the value attached by respondents to effective support in practice and the impact of both positive and negative role models on their learning. This category will be discussed in relation to support and role models as demonstrated in diagram 5 below.

Respondents explained the systems in place to support their learning during practice placements. Nursing students were allocated a mentor for each placement area, midwifery students were supported by the entire team to which they were allocated and social work students had a work based supervisor and a practice teacher who was often based outside of the placement organisation. It is evident from the data that mentors and practice supervisors had a major impact

Diagram 5: Examples from the Data to Illustrate Category 1.3 - Facilitation of Learning

'She was always there if I needed to speak to her about issues, which really, I suppose would be almost every day at the beginning'. *(R10, MU4)*



'I realised that I had to learn, if you can't learn from one person I had to search for, you know, for other experience for information other people'. (R5, MU9)

on respondents' experience of learning but that this was largely in terms of support rather than active facilitation of learning.

4.1 Support

The data indicate that all respondents valued the support provided by their mentors and practice supervisors. For example, R10 describes very effective supervision within a social services organisation. She had regular, formal supervision sessions which provided intensive support at the beginning, and then decreased throughout the placement, as she gained confidence:

> *'She was always there if I needed to speak to her about issues, which really, I suppose would be almost every day at the beginning'.* (R10, MU4)

> *'Yes you've got somebody to go to after those experiences and to say you know I found this really hard and to deal with family'.* (R2, MU7)

> *'Erm, I don't think so really. I think just, as long as you know you've got the support there, I think that's the important thing really. Having somebody you can go to when you're struggling, you know, because I know people are busy or they're not in the*

office or not there, but there should still be, you still feel comfortable with asking questions and I didn't initially'. (R11, MU2)

Some respondents had experienced placements in which they had not felt supported. For example, R5 explains that he had approached other professionals when his mentor was not supportive:

'That was the only time I felt like, you know, I wasn't supported at all. But the placement was so nice, and everybody else was so good, so I wasn't really bothered to have that named mentor…… I think after having experience of this mentor, I realised that I had to learn, if you can't learn from one person I had to search for, you know, for other experience for information other people'. (R5, MU9)

Respondents were able to clearly articulate their views of effective mentors and these were largely in terms of relationships, for example:

'Erm, I think when they put themselves in your shoes, they assess what you can do, they interact with you and treat you as one of, in level with them really. They don't treat you as a student you know. And discuss what you're doing and why you're doing it, and is there anything, they ask you if there's anything you want to ask. They interact with you basically. They don't just leave you to go and do

it, unless you are capable of doing it and are happy to do it'.

(R3, MU9)

These findings are consistent with the literature reviewed in chapter two. Despite the different roles identified to support students from nursing, midwifery and social work programmes, there is a common theme in relation to the importance of the relationship between the student, lecturer and mentor/practice teacher. In relation to nursing and midwifery education programmes there are numerous publications relating to this issue (Kotzabassaki et al., Li, 1997; Lee et al.,2002; Lofmark and Wikblad, 2001; Morgan and Knox, 1987; Nehring, 1990;). Social work students are supported and assessed in practice by practice teachers and the literature highlights their vital role in promoting learning (Bhattacharya, 1998; Billingham, 1999; Bucknell, 2000; Cartney, 2001; Dick et al., 2002; Kennedy, 2001). An effective relationship is considered to be a partnership approach with students and an ability to relate to colleagues (Gillespie, 2002; Spouse, 1998). Students value regular contact with their mentors and the quality of mentorship they receive has a major impact on the quality of their learning during clinical placements (Higgins and McCarthy, 2005).

R12 provides an example of both effective support and facilitation of learning in relation to her role as a social work student in the care of a patient in a psychiatric ward:

'There was another one, who, erm, I accepted him as a new referral, I wasn't he hadn't been allocated to anyone else before me, he was new to the team and he, it was right at the start of the placement and an ASW had already gone out to do an assessment and then they were going back and ….they hadn't had a psychiatric assessment, it was a referral that had come from community, from … in the community, erm, about erm, a deterioration in his mental health. And he's, he's had, he's been a schizophrenic for about twenty years…….diagnosed for twenty years, but for ten years hasn't received any services, because he's erm, remained stable and just got on with you know, his own life, basically. There had been a sudden deterioration and he agreed to go into psychiatric hospital informally, erm, with a request, a request made for social work involvement so I had my first meeting with him in hospital, but because it was the first meeting, because he was, erm, male and it was the first meeting, nobody really knew, you know, sort of where he was at. So another social worker, a male social worker, came with me to the meeting, really to assess whether I was suitable, and whether he accepted female workers, because one of the things we've been told about this patient was that he was having a lot of problems with impotency and you know, a lot of sexual frustration and things like that, so that's where it might it have been inappropriate'.

(R12, MU 15)

She is able to identify her own learning from her experience with this patient:

But I think again, that was about me not really understanding the l evels of his mental illness and I was just trying to be too kind I think. It's the fear of, I didn't want to offend in any way. So it's, I don't know, it was a difficult one, I just understood that that was part of his illness, that was what he was feeling, I had to respect that, and allow it in some ways. But I think I might have been a bit more assertive in how he did it and how it was kind of structured. I think if I was going to allow him to talk about it, I would direct the conversation and it would have been a timed and scheduled and planned thing rather than just keep blurting things out. And we actually used this person for one of my observed practices ……..so I was able to take the practice teacher, to introduce her and she observed me with him. It was near the end and I think I also wanted her to have an understanding of why I was feeling like I did, through supervision and she fully understood where I was coming from and she said he was a very ill person and there was not a lot different I could have done, you know, so I felt good that way'.

(R12, MU 17)

As discussed previously, the above example also demonstrates the concept of learning in the zone of complexity. The practice teacher provided support to facilitate R12's learning from this experience but also provided the pedagogical space for her to develop her own knowledge. The final chapter will explore this

further, in relation to the roles of mentors and practice teachers in harnessing the complexity of learning in practice settings.

Several respondents highlighted problems associated with practice learning. This included the fact that, contrary to professional requirements, they were often not supernumerary. Other issues included shortage of appropriate placements, the unrealistic expectations of some staff, and tensions between staff within the organisation. R2 reported that community based mentors were evaluated more positively by students than hospital based mentors. However, he recognised that this may be related to the larger number of students allocated to hospital settings.

> *'Some students perhaps need a bit more guidance. When I go on to my ward placements, I've always got my learning outcomes and put them all in a folder and put what want to achieve. I give them to my mentor and my ward manager and I still often struggle to get things done. I think training's difficult. It's difficult at the moment because it's going through a bit of a change'.* (R4, MU14)

> *'No, no, I felt that, because you've got learning outcomes to achieve that you were always, not best behaviour that's perhaps…… but you wanted to make a good impression and you were out to make a good impression all the time because you know that your mentors have got to do a report on you'.* (R1, MU10)

'The practice teacher – I was her first student …Yes, and she was a bit nervous, well not nervous, I would say, erm, apprehensive, about what her role and what she had to do she was good, she was very thorough, she thought being thorough, but I thought she was being a bit too….You know, not always aware of all the issues and what we covered……I had the support from everybody, but it erm, was difficult, because I mean, the practice teacher should to know what exactly I was doing, because she had to write the report about me….'. (R11, MU3)

4.2 Role Models

Role models in practice were reported as being mentors, practice teachers and other professionals. Examples of learning from role models included developing effective professional relationships, dealing with difficult situations, developing relationships with children and reprimanding a colleague inappropriately. R2 explains that nurses who are positive role models in terms of patient care are also effective mentors:

'You can't sort of be good with the patients and then blank the students'. (R2, MU 16)

R6 and R7 both explicitly stated that they had developed their own approach to professional relationships with women, during their midwifery programmes, by observing positive and negative role models in practice.

> *'Probably yes, because you learn from your practice and I've probably learned from watching other midwives with women and watching their relationship and seeing how far to get involved and when to take a step back and things. Because when I first started all I wanted to do was just hug everybody and say "Oh it's going to be OK, you're going to be alright, you're going to be fine!"* (R7, MU10)

R6 provides a striking example of how she consciously learned from positive role models and one negative role model within a midwifery team:

> *'Yes, I mean you pick up bits off everybody don't you? Some midwives are quite abrupt and just say this is the way it is and this is the way you're going to do it. 'Yes some are quite abrupt and they tell the women "it's like this and this is where you're going to be and this is what will happen and blah de blah de blah". And then others are very nicey, nicey and very airy fairy and touchy feely. And I've just sort of picked a little bit from everyone of them. And my team leader said to me, right at the beginning of me training – you'll find that some people do things that you think "aah that's terrible", and some people do things that you think "how wet's that?" and you'll*

just pick bits from everybody and you'll get your own way of, erm, being with the women basically. And yes. I've took a little bit from five out of the six in my team, I think I've took a little bit of the way they work and made my own way'. (R6, MU10)

When asked how the other midwife in the team had influenced her, she replied:

'I know what not to do!' (R6, MU10)

Valentine (1997) describes positive role modeling as that which is desirable for the professional development of the student, and negative role modeling as including behaviours that are unprofessional, unethical or inappropriate. Valentine argues that, as role modeling relies heavily on observation and imitation, both positive and negative behaviours can be adopted by the students. This is not consistent with the findings of this study in which students consciously learned from both positive and negative role models, but rather than imitating poor behaviour used this to determine how not to behave. R5 actively observed other professionals in terms of their interactions with patients, but recognised that they were often unaware of their influence as role models:

'In my case it's never been the mentor itself, always to see other people …..just listening, you know, just observing them, see how they…..I don't think they realise they are being watched all the time, every single movement, how they talk to the patient and things'.

(R5, MU 9)

R11 also actively learned from role models in practice:

> *'I used to watch how social workers would work, and they all did the initial assessment differently, and I took the best, I think I took the best'.* (R11, MU 13)

> *'Just listening, you know, just observing them. See how they, I don't think they realise how, erm, they are being watched all the time, every single movement, how they talk to erm, to the patient and things and its up to you to say "right OK I'm not going to be doing that, or yes that's her"'.* (R5, MU9)

R5 provided an example of working with a positive role model early in his programme; he reflects on her attitude and relationships with patients:

> *'Yes my first year I had a sister and she was very good…. she was absolutely fantastic, her as a person as well you know the patient would say "oh sister – yes - sit down" and she would talk to them. You know and it was very kind the way she just related to them and her bedside manner was fantastic'.* (R5, MU 10)

R9 explained that although on one placement, she had reflective sessions; this

was by no means common practice throughout her programme:

> *'Sometimes, if the mentors are doing your OSCE, at the end of every shift, or the beginning of the next shift, for practice and things, my mentor will say – "how do you think this shift's gone", …. you know "do you need to talk?" and things. We've been doing it a lot more on this placement than we have before'.* (R9, MU11)

It was evident that the ways in which other professionals interacted with patients and clients was very influential in students' learning. The researcher decided to incorporate role models within the facilitation of learning, because it was evident from the data that this was a learning strategy from which students, indirectly, learned from patients and clients. Although role models are an influential part of professional education it is apparent from the data that the staff, who were observed by students, were often unaware that they were acting as role models. These findings are consistent with publications over the past two decades that students are influenced by role models in respect of professional behaviour and approaches (Davies, 1993; Morgan and Knox, 1987; Wiseman, 1994). Davies (1993) reported that students learned the artistic rather than the scientific aspects of nursing from role models in practice, encompassing values and the nature of the nursing role and that almost all of the experiences focused on nurse patient interactions. The data also support Woodward's (2003) contention that students develop their own understanding of the patient's world and of the role of the professional within this by means of role modeling.

It is evident from the data that a range of systems are in place to support students during their nursing, midwifery and social work programmes. Students reported that the quality of support provided during their practice placement had a major impact on the quality of their learning. However, there was limited evidence that mentors and practice supervisors actively facilitated learning. All respondents recognised their learning from both positive and negative role models in practice and they had used their observations to influence their own philosophies of care.

The roles of practice supervisors and mentors include student support, developing the learning environment, the facilitation of learning in practice settings, and the assessment of students against specified competencies (GSCC 2002b; NMC, 2007). Mentors (for nursing and midwifery students) and practice teachers (for social work students) are consistently reported in the literature as having the most influential role in student learning and assessment in practice. The findings of this study support the consensus in the literature that the relationship between students and mentor/practice teachers is an important factor in relation to student learning on placements.

The data from this study support the contention in the literature that experiential learning is a valuable aspect of student learning. However, it is apparent that in the context of this research, mentors and practice teachers had a limited role in actively facilitating learning from patients and clients. Although the role of

mentors and practice supervisors is clearly defined in relation to learning in practice settings, professional regulations and guidelines do not currently refer explicitly to learning from patients and clients. This is consistent with the literature reviewed in chapter three, which focused on patient and client involvement in professional programmes but with very little reference to this learning in the context of practice settings. This is surprising in light of the emphasis on practice learning within health and social care education. The findings of this study indicate that students did access opportunities to learn from patients and clients during their practice placements, but that this was not actively facilitated.

5. Conclusion to Chapter

This chapter has presented the findings of the research study in relation to the first theme which was extrapolated from the data; that is, the 'Ways of Learning' in practice settings. The data were considered with reference to existing bodies of literature relating to learning in practice settings and learning from patients and clients, which were presented in chapters two and three respectively. The main influences on learning reported by all twelve respondents were their own motivation to learn (and to overcome a range of challenges) and their interactions with patients. All respondents reported experiences of patients' stories and critical incidents, from which they developed their own philosophies of professional ideals, including the nature of effective relationships and

understanding patients' and clients' perspectives. Respondents also observed other members of staff as both positive and negative role models, and they consciously used these observations to develop their own personal philosophies of care. Professional ideals, developing relationships and understanding patients' perspective were the major focus of learning reported by all respondents in this study. These will be presented in detail in the following chapter, which focuses on the second theme extrapolated from the data; that is, the nature of learning.

Students' commitment to their programmes and their motivation to learn was apparent in all interviews and it was evident that they had succeeded despite many challenges. However, it is acknowledged that this may have been biased by the sampling approach adopted within the study. Respondents all volunteered to participate and may, therefore, have been more committed to their programmes than those who did not volunteer. There is an increasing interest in student attrition within professional programmes, because of the financial impact on the institution, the negative effect on students and the shortfall for the profession. The data highlights that respondents faced many challenges in terms of competing priorities and workload: this research supported Barnett's (2007) proposal that students' will to learn is vital to their success.

Much of the data is consistent with the literature reviewed in chapters two and three, but there were some surprising results. The findings from this study are consistent with the literature which suggests that learning from patients is a

valuable strategy to promote student learning. As discussed in chapter three, this literature refers to patients telling their stories in university classrooms, with very little emphasis given to learning from patients in practice settings. However, the data in this study provide evidence that all of the respondents accessed opportunities to learn (during their practice placements) from a range of individual patients, and that they used this knowledge to influence their practice. There is consensus in the literature that practice experience is a vital aspect of nursing, midwifery and social work programmes. The data from this study support the literature relating to the importance of mentors and practice teachers, in respect of their relationships with students and supportive roles. The literature suggests that learning in practice is complex and that it requires a planned, co-ordinated approach. The findings of this study demonstrated that respondents had experienced powerful learning from their experiences with patients and clients. However, in the majority of instances, this learning occurred without active facilitation by experienced professionals.

It is evident that experiential learning was a major aspect of the learning described in this study. Kolb's theory of experiential learning has been described as having a major impact on the move from a reductionist to non-reductionist perspective in education (Kelly, 1997) and his experiential learning cycle has been highly influential in professional education (Cree et al., 1998). However, theories underpinning experiential learning propose that learning from experience requires more than experience alone and that learning occurs as a separate process from the experience, following conscious reflection (Andrews, 1995;

Freire, 1994; Hogan, 1995; Kolb, 1984; Miller and Boud,1996). However, in contrast to these views, there was little evidence in the data of this deliberate action.

Although it is not the intention of this study to make comparisons between the professional groups, there were some interesting differences identified. Social work students did not discuss their motivations for joining the profession, whereas all nursing and midwifery students did. All students reported learning as experience and learning as status; all recognised both positive and negative role models; all discussed learning from patient stories/critical incidents, but only the nursing students reported critical incidents within their personal lives. The data support the findings of recent research which also demonstrates the effectiveness of critical incidents to promote student learning in practice (Bradbury-Jones, Irvine and Sambrook, 2007; Bradbury-Jones, Sambrook and Irvine, 2007).

Reflection is a requirement of professional regulatory bodies and is incorporated into undergraduate, pre-registration nursing, midwifery and social work programmes (GSCC, 2002a; NMC, 2004a; 2004b). It is also a specific outcome within programmes to prepare nurse lecturers and mentors (NMC, 2006) and practice teachers (GSCC, 2002b). Despite the fact that reflection is widely advocated to promote learning from experience and the integration of theory and practice in professional programmes (Gidman, 2006), there is currently a limited

evidence base to support its widespread implementation (Lethbridge, 2006) and no commonly accepted definition (D'Cruz et al*.,* 2007).

Although it was evident that reflection occurred following many of the experiences described, in the vast majority of instances this occurred without any active facilitation by mentors, practice supervisors or lecturers. This supports the findings of a previous study of learning in practice by the researcher (Gidman, 2001a; 2001b), in which nursing students described learning following critical incidents but with little evidence that mentors or lecturers facilitated reflection. This challenges much of the extensive literature relating to reflection in professional education, which indicates the need for students to reflect on experiences as soon as possible and advises that mentors and practice teachers should facilitate this process. This was not evidenced in the data from this study; indeed as discussed previously, the most powerful learning experiences occurred without active facilitation by other professionals. It is also interesting to note that, despite the absence of conscious reflection in the transcripts, there was considerable evidence of deep learning and changed conceptual perspectives in students' responses.

The data from the interviews also provide evidence that respondents all accessed alternative forms of knowledge and that they experienced learning in the zone of complexity. This is consistent with the view that the closer an individual moves towards the edge of chaos the more powerful the learning opportunity (Santanus, 2006; Stacey, Griffin and Shaw, 2000). It was also

evident that effective support by mentors and practice teachers prevented situations being perceived as chaotic, which it is suggested would inhibit learning (Doll, 2008).

It is widely recognised that expert practitioners act as role models of good practice for students undertaking professional programmes and that, as discussed in chapter three, modeling is a major learning and teaching strategy used by mentors and practice teachers. Bandura's (1977) social learning theory emphasises the importance of learning from the observation of the behaviours and attitudes of others. It incorporates cognitive and behavioural aspects, recognising the continuous interaction between cognitive, behavioural and environmental influences. The experiences reported in this research study demonstrate that students learned from observing both positive and negative role models in respect of professionals interacting with patients and clients. However, the literature suggests that students may also adopt inappropriate behaviours modeled in practice, but this was not evident in this study. Indeed, several students clearly articulated their learning from negative role models, when they had observed incidents during which professionals had behaved inappropriately. However, they were able to clearly articulate this learning in terms of what not to do, rather than adopting inappropriate behaviours themselves. It was also evident that respondents recognised when professionals used their expert power base, rather than promoting patient and client empowerment, and they all voiced their own values in relation to patient/client centred care. Students' values were

consistent with the empowerment approach of current government policy to reform health and social care.

The conclusions of this chapter led the researcher to continue to reflect on complexity theory in relation to the development of this thesis. This chapter presented the ways in which students learned from patient stories. Although this learning strategy was reported by most respondents, it was not prevalent in the literature reviewed earlier in the thesis. The data include a range of experiences which led to students learning from the subjective perspectives of patients and clients themselves. This is consistent with the notion of alternative forms of knowledge advocated in complexity theory to complement the traditional positivist perspective of knowledge (Greenhalgh and Collard, 2003).

Although the data demonstrated that students perceive that mentors and practice teachers have a major role in supporting them during their practice placement experience, there is limited evidence in relation to the strategies used to promote learning from patients and clients. The emphasis on networks, connectedness, relationships, communication, feedback and human agents was evident in the data presented in this chapter. Students reported that they learned from a range of agents (patients, clients and professionals) during their practice experience, but the complexity of these interactions was not formally recognised. There were few examples of mentors or practice teachers facilitating learning from these networks, which led the researcher to consider ways in which this learning could be enhanced. This is consistent with the holistic nature of complexity

theory, which incorporates order and disorder and values competence and alternative forms of knowledge (Cooper and Geyer, 2007; Fraser and Greenhalgh, 2001; Plsek and Greenhalgh, 2001; Sweeney, 2002). This is directly relevant to the requirements of professional programmes and is discussed in greater detail in the final chapter of this thesis which proposes a range of strategies to harness the complexity of learning in this context.

Respondents described a number of experiences in which anxiety and uncertainty stimulated learning from critical incidents. This can be related to the notion of learning in the zone of complexity, which is one of the major constructs of complexity theory. However, there were also reports of experiences in which high levels of anxiety inhibited learning and in which support was not available to debrief students. The data indicated that effective learning from patients and clients in practice placements requires new ways of thinking and the supports the consideration of alternative theoretical frameworks in this context.

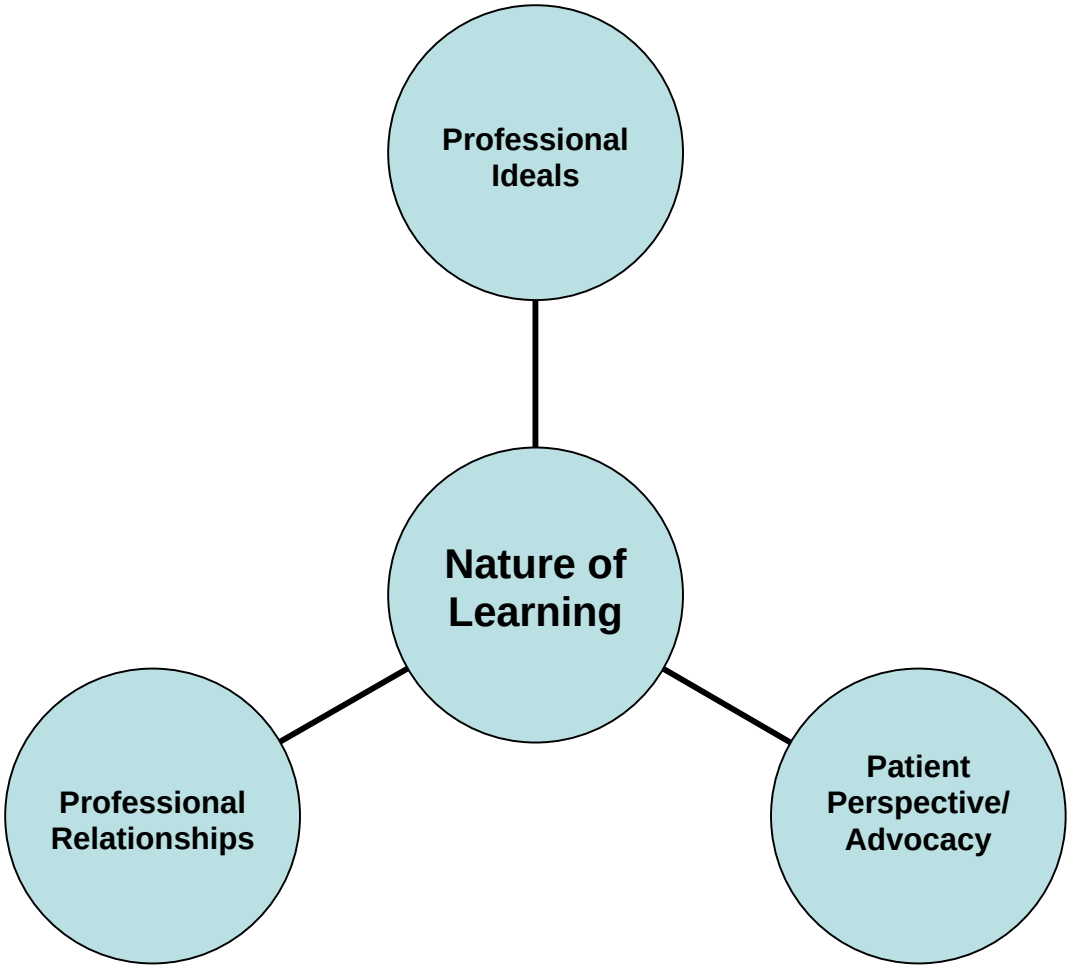
Chapter 7: The Nature of Learning

1. Introduction to Chapter

This chapter will explore the data in relation to the second theme which was extrapolated from the data; that is, the 'Nature of Learning'. Within this second theme, three categories were identified: professional ideals; professional relationships; and understanding patients'/clients' perspectives (Diagram 6). As in the previous chapter, in line with the descriptive phenomenological approach adopted by the study, extracts from the data will be used verbatim, as reported by respondents, to illustrate the findings.

The main findings in relation to the nature of learning, from patients and clients in practice settings, were around the tacit knowledge associated with professional values and relationships, rather than on knowledge or skills. As discussed in chapter one, the literature identifies a lack of consistency in the nature of professional knowledge, with professional programmes becoming increasingly competence based. However, the students who were involved in this study described their learning from patients and clients, in terms of relationships and philosophies of care, rather than skills and profession specific knowledge. As discussed in the previous chapter, this learning occurred from critical incidents, patient stories, interactions with patients and clients and observation of both positive and negative role models.

Diagram 6: Theme 2 - Nature of Learning



It is apparent that students were self-motivated in their learning and there was little evidence of active facilitation by mentors, practice supervisors or lecturers. However, it is important to note that any conclusions drawn can only be applied to the specific focus and contexts of this study.

The data revealed that the 'Nature of Learning' reported by the respondents focused primarily around professional ideals and relationships, with learning as knowledge gained and as relating to others. Professional ideals were viewed by all respondents in terms of quality of care and the role of the professional. The data focus largely on the relationships between professionals and patients/clients, and all students reported that these should be based on trust, honesty, respect and equality. All respondents recognised the need to understand the patients'/clients' perspectives and to respond appropriately. The data provide many examples of situations in which students had acted in an advocacy role. Respondents also analysed the philosophies and systems of care which they had encountered and challenged these in terms of patient/client need. However, many recognised that the realities of practice, in terms of competing priorities and resources, may prevent them from realising their ideals in terms of professional practice once qualified.

The large scale modernisation agenda, within health and social care, promotes patient centred care and integrated services. A wide range of policies have been introduced during the last decade to increase public involvement in all aspects of health and social care. The central tenet of many of these policies is that

patients and clients should be recognised as experts in their own care and treated as active participants rather than passive recipients of that care. These principles of person-centredness and autonomy required a change in the roles of professionals. Professionals have traditionally been viewed as experts, due to their specialist knowledge base, but the new philosophy of care requires them to promote independence and to facilitate the decisions of patients and clients. The data presented in this chapter include a range of examples of the nature of care experienced by patients and clients which, respondents reflected, were often not patient centred in their approach. Respondents demonstrated a humanistic and authentic approach to developing relationships with patients and clients; they were non-judgemental and tried to understand the situation from the patients' and clients' perspectives. The data indicate that these students shared the ethos of patient centred care which is central to health and social care reforms. However, in many cases they observed care which was not consistent with these policies and, in a number of the examples reported in this chapter, respondents challenged these systems. They attempted to understand the situation from patients' and clients' perspectives and acted as advocates for them with other professionals.

Another major aspect of the government reforms is the promotion of integrated services across a wide range of health and social care organisations, including the voluntary and independent sectors. This has a corresponding requirement for inter-professional working across a range of agencies, with care based on patient need rather than relying on traditional organisational responsibilities. As

will be discussed below, the data provide several examples where this integrated approach was not evident in practice. Respondents also report difficulties in developing effective working relationships with colleagues from different professions and in different agencies.

This chapter will now continue with a discussion of the data, in relation to the government policies and literature reviewed earlier in this thesis. This will be presented in the three categories identified within this theme:

- Professional ideals
- Professional relationships
- Understanding patients' and clients' perspectives

The identification of this theme and its constituent categories was facilitated by mapping the mapping units extrapolated from the data (Table 13). It is evident that many of these meaning units were also included in the previous chapter 'Nature of Learning', which indicates the notion of simultaneity between the ontological and epistemological nature of knowledge in this study.

Table 13: Theme 2 - The Nature of Learning

Table to Demonstrate Categories Extrapolated from the Data

Theme	Category	Interview/meaning unit
Nature of Learning	Professional ideals	1.16, 1.17, 2.5, 2.6, 2.10, 2.11, 3.6, 4.10, 5.6, 5.7, 7.10, 7.18, 8.5, 8.11, 8.13, 8.17, 8.23, 9.12, 10.16, 11.14, 11.17
	Professional relationships	1.7, 1.8, 1.9, 1.11, 1.12, 1.13, 1.14, 1.15, 2.7, 3.6, 3.11, 3.12, 3.15, 3.16, 3.18, 4.3, 4.4, 4.7, 4.13, 5.3, 5.4, 5.7, 5.12, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 7.6, 7.7, 7.8, 8.2, 8.12, 8.20, 8.24, 9.4, 9.6, 9.7, 9.13, 10.7,10.11, 10.15, 11.8, 11.9, 11.13, 11.14, 12.5, 12.7, 12.15, 12.16
	Understanding patient's/client's perspective	1.4, 1.5, 1.6, 1.8, 1.12, 1.13, 2.8, 2.12, 2.13, 3.11, 3.12, 3.13, 4.4, 4.5, 4.6, 4.10, 4.12, 5.5, 5.8, 6.12, 6.13, 6.15, 7.8, 8.6, 8.11, 8.14, 8.16, 8.18, 8.24, 8.26, 9.4, 9.5, 9.6, 9.16, 10.8, 10.11, 10.12, 10.13, 11.8, 11.10, 12.4, 12.6, 12.7, 12.9, 12.10

The ‘Nature of Learning’ reported by respondents in this study relates mainly to personal knowledge gained from a range of individual experiences, rather than the body of public knowledge which is commonly associated with the relevant professions and taught in the university setting. The following sections present the data in this theme, but it is important to note that this is closely related to the previous chapter which presented the ways that students acquired that learning.

2. Professional Ideals

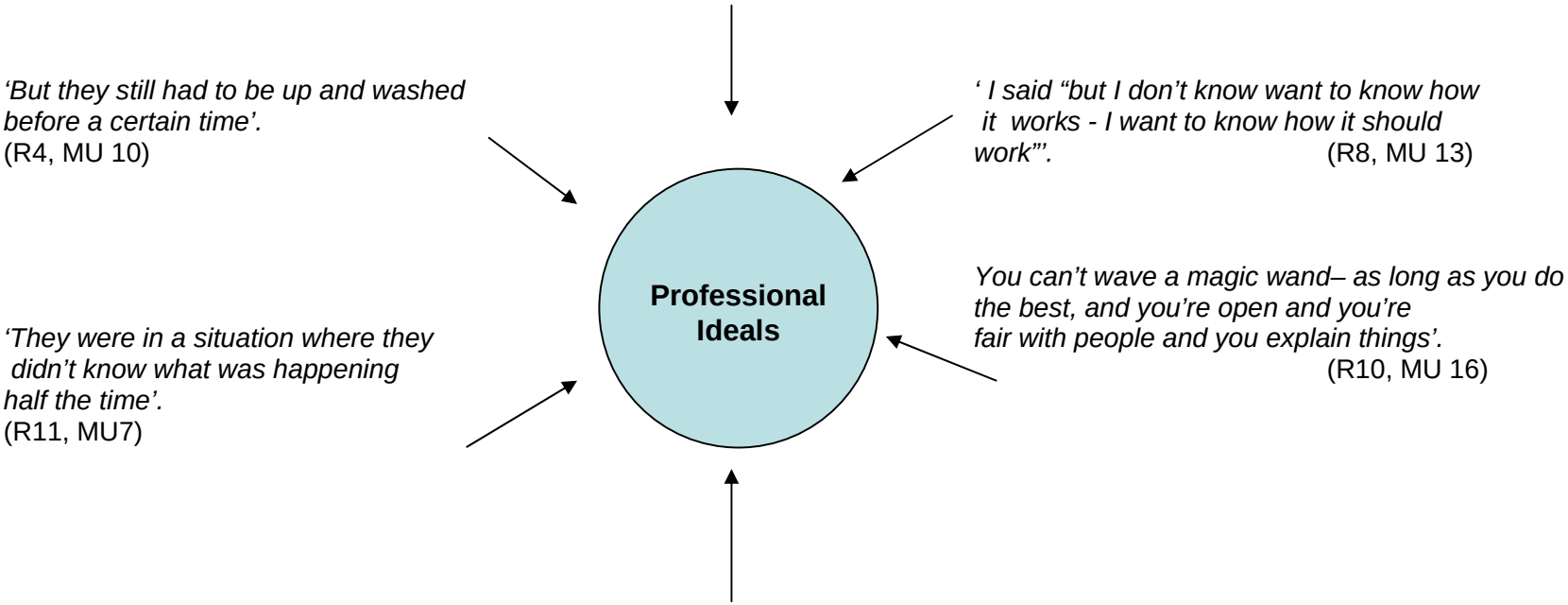
The data indicate that respondents in this study perceive professional ideals in terms of the roles of professionals, their relationships with patients and clients, and the quality of the service they provide. This category, professional ideals, will focus on roles of professionals and the quality of service experienced by patients and clients. Extracts from the transcripts will be discussed in relation to government policies which were considered in detail in chapter one. These policies promote a patient-centred approach to health and social care, with increased public involvement in decision making and equal relationships between patients/clients and professionals.

This category will be discussed in relation to quality of service; patient/client empowerment; and systems of care, as illustrated by the examples of data in Diagram 7 below.

Diagram 7: Examples from the Data to Illustrate Category 2.1 - Professional Ideals

'Hopefully, as I get more advanced and speed up a bit I can still spend the time with the patients'. (R1 MU 17).

'…they're not able to take the time,
whereas as a student I'm a bit more able to sit with the patient and spend the time'. (R2, MU 11)



2.1 Quality of Service

Respondents describe both positive and negative experiences in relation to the quality of service experienced by patients and clients, and several challenge the systems of care that they encountered. R11 reflects on the quality of social care services she observed and recognised her own role in providing this service:

> *'I do feel that I do work with everybody well and perform my job…..*
> *as long as I've delivered the service, that's the main thing really'.*
>
> (R11, MU17)

The previous chapter identified many challenges associated with respondents' engaging with professional programmes; R11 acknowledges the difficulties involved in delivering a quality service in social care and the effect that this had on her personally:

> *'…….to maintain a high level of erm, erm, quality in the work,*
> *because sometimes that was very difficult - it was very stretched*
> *and I just couldn't get rid of these headaches'.* (R11, MU 4)

Several respondents express concern that they will not have time to fulfill their own expectations of professional ideals, once they are qualified, due to other commitments, time pressures, staffing difficulties and lack of resources to provide effective services. For example, R1 recognises the importance of listening to patients, but she acknowledges the difficulties experienced by qualified nurses who try to spend time with patients. She observed the amount of time it took to complete discharge paperwork:

'One thing we haven't been taught in school is discharges, and all that side of it and how to discharge ….. and you know social services and that sort of thing, you're not taught any of that. But that is what takes up the majority of time once you're on the wards'. (R1 MU 17)

R1 expressed her concerns about how she will maintain effective relationships with patients when she has the additional responsibilities of qualified nurses:

'At the moment, I mean the workload, I'm not taking, I'm taking about six patients at the moment and that's fine I can manage them. Hopefully, as I get more advanced and speed up a bit I can still spend the time with the patients.' (R1 MU 17)

She has observed positive role models on the wards but perceives that they have to work additional hours to maintain that aspect of their role:

'Yes. Although they end up staying at their end of their shifts…so they can do all of it and work that they haven't done'. (R1 MU 17)

R2 comments about qualified nurses:

'…they're not able to take the time, whereas as a student I'm a bit more able to sit with the patient and spend the time. Which is quite sad really, because I think I'm hoping that doesn't happen when I become the staff nurse, that I'm rushing round doing stuff and not able to spend time with

the patients'. (R2, MU 11)

Systems of care are challenged by several respondents. For example R2 and R4 question the need for task orientated routines:

'There is this routine when you come on at half past seven, quarter to eight in the morning and go into the bay, patients up to the bathroom... ….let patients get up when they want to and does it matter if they are still in bed when the consultant comes round? No it doesn't really'.

(R2, MU5)

'And there needn't be. On the (names area), it was, erm, everybody has to be washed and dressed by a certain time. You've basically you've got people there that are mostly independent. If they don't dress until ten o'clock in the morning why should they? If they can take themselves off to the bathroom anyway and have a wash it makes no difference to us whatsoever….But they still had to be up and washed before a certain time…….because there wasn't a ward round every day. You could gear that to, you knew when the doctors were coming round anyway. So you could, as long as they're in bed, they don't have to be washed do they? You can say "well so and so wanted to have a little sleep, they've had their breakfast but …." '. (R4, MU10)

2.2 Patient/Client Empowerment

As highlighted in chapter one, one of the major reforms of health and social care in recent years has been the emphasis on public involvement in all aspects of decision making, including the planning, delivery, and evaluation of services (Chief Medical Officer, 2001; D.H., 2000a; 2000b; 2003a; 2003b; 2003c; 2004a; 2005; 2006a). However, the extracts from the data above indicate that R2 and R4 had observed systems which were not patient centred. They recognised that these systems of care were designed to benefit professionals, rather than to meet the needs of patients.

The data provide a range of examples of experiences in which patients and clients were not actively involved in decisions about their care. For example, R8 cared for an elderly woman who was diagnosed with cancer, but was not kept informed during the investigations:

> *'You know, somebody should have sat down from the mammogram and said "they've identified……I think there's more …." Nobody bothered to take that step. It's probably bad communication - the fact that she was deaf. But she could hear if you took time out to talk to her.'* (R8, MU24)

R8 also observed the discharge of another elderly woman, from a ward to a nursing home, and perceives that decisions were made on the basis of resources, rather than patient choice:

> *'I mean, for whatever good purposes, they've got to be discharged because it becomes a social issue'.* (R8, MU6)

R11 expresses concern that parents, who were involved in a child protection case, were not actively engaged in, or kept informed about, decisions relating to the case:

> *'Maybe because I had more time than the other social workers – I don't know…. but I just felt that I needed to, and I wanted to build up their trust in me, although there were things that I, I would never promise anybody anything, but I always like knew that they were in a situation where they didn't know what was happening half the time and there was only so much information I had ….everyone's ganging up on them...'* (R11, MU7)

R5, whilst acknowledging staffing shortages, feels that professionals have a choice of whether to conform to existing systems or to challenge these:

> *'Just, when you qualify you can either say now I'm going to change these and I'm not going to be rushing around trying to do everything at once. Or you just go along with it, the system, just kind of missing out things that, you know, things that should have been done really'.* (R5, MU6)

R5 perceives that professionals should have a positive impact on patients:

> *'I felt, you know, this is it, this is what we're here for. And it can change, make a difference in someone's life'.* (R5, MU7)

2.3 Systems of Care

R4 reflects that she consciously analyses different systems of care and hopes to change practice once she has qualified as a professional and is in a position to influence care:

> *'I think it makes a difference if you can take it on board and you can make a mental note of how things are being run, because when you come to end of your training, erm, you can perhaps do it differently'.* (R4, MU 11)

R8 reflects on a discussion with a lecturer in relation to the systems in place to obtain consent from people with learning disabilities. She was surprised that he appeared to be condoning what she perceived as poor practice:

> *'He said that's not how it works. And I said "but I don't know want to know how it works - I want to know how it should work". I want to know what the gold standard is and then you can tell me how I cut corners really. …..Well no, he was saying this is how it happens basically and that's - well I don't want to know how it happens, I want to know how it should work'.* (R8, MU 13)

R10 expressed concerns about systems of care, in relation to the roles of social workers, who she perceived often had to work with inadequate resources. She recognised that lack of resources limited her ability to arrange appropriate support for clients and she reflected that she became more realistic about this during her programme:

> *'Because the resources were awful, here in (names place) wasn't the ideal place for someone with dementia. It was having to be very creative, you*

know I could understand their ….I think it was, I think it was, a big thing it can put a lot of pressure on me as a worker – that sort of – that's the main pressure isn't it? As a social worker, it's trying to liaise between all these people and it's that pressure as well….to understand where this is coming from to be able to deal with it……Because you know you're only human, you know your limitations and another thing that I learned – to begin with I was taking it all on my own shoulders and I have learned not to do that. It wasn't my responsibility…you know – I got very fond of her – not my responsibility to get things sorted out in this family and do my best…… You can't wave a magic wand – as long as you do the best, and you're open and you're fair with people and you explain things and use the team and just …..'. (R10, MU16)

This response provides an example of care which is not consistent with the ethos of the policies reviewed in chapter one. For example, social service reforms included a change from local authority provision to individual budgets to improve choice (D.H., 1998). Patients and clients should now be recognised as experts in their own care and treated as active participants in service delivery, not as passive recipients (D.H., 2002a; 2002b). However, in the case reported by R10 above this choice was severely restricted by lack of resources. The principles of person-centredness, autonomy and promoting independence are central to the modernisation programme. Patient centred care is not a new concept, it has long been advocated in health care (for example, Balint, 1964, Tuckett, Boulton, Olson and Williams, 1985; Warne and MacAndrew, 2005; World Health Organisation, 1991). This poses challenges for the role of the professional, who should facilitate the decisions of patients and clients, rather than adopt the role of expert and should ensure that control rests with the individual (Skidmore, 2005). However, the

extracts from the data above, in which R8 and R10 highlight difficulties with patient-centred care in practice, are consistent with Scourfield's (2007) concerns about the impact of these principles on vulnerable people in society.

This is an interesting finding but since neither student or patient/client empowerment were the focus of this research, conclusions cannot be drawn at this point in relation to possible correlations. However, this is an issue which will be considered further in the final chapter of the thesis, in relation to recommendations for further research.

Another major aspect of the modernisation agenda for health and social care is the development of integrated services across a wide range of health and social care organisations (for example, D.H., 2004c). As highlighted in chapter one, it is evident that multi-agency working is essential, in order to respond to these policy drivers to integrate service delivery (Dowling et al., 2004; Edwards and Miller, 2003; Glasby et al., 2006). However, R12, a social work student, experienced difficulties when communicating with a community psychiatric nurse about a patient referral:

> *'Because when I, before I phoned this lady, before my first approach to her, I phoned the CPN to explain what I was doing, why I was doing it, and again she turned round and said "why are you getting in touch – she doesn't want you" and I said "well I understand that but I am a student and I've been informed that we've got to do this, that we've got a duty and I just want an update of where she is, at the moment" She really didn't want to help me and because of the documents, the assessment documents had been written again, they are supposed to be joint because she didn't have access to the Otta system, I couldn't initiate the Otta, because I wasn't the*

> *care coordinator – she was the care coordinator. So I had to request that she sent her copies, it took, in fact it took the two managers to phone up and ask for them'.* (R12, MU10)

These difficulties support the literature reviewed previously, which suggests that, despite the prevalence of inter-professional working in government policy, barriers remain which inhibit this. These include structural divisions, separate legal and financial frameworks, differences in governance and accountability and distinct professional and organisational identities (Glasby, 2003). The extract above also supports the conclusions that differences still exist between the professional groups in respect of professional identity, professional status and professional discretion, and accountability (Hudson, 2002), which adversely affect the exchange of information between professionals (Richardson and Asthana, 2006).

The findings demonstrate the importance of networks and relationships; it is apparent that students learned from a range of individuals in practice settings. Complexity theory recognises the interactions among the constituent elements in a system and the importance of the agents within the system (Mason, 2008b). As previously discussed, systems which include human agents have additional complexity in terms of norms, values, language and narratives and the effects of these were evident in the data. The agents in practice settings include staff, patients, clients and students and these potential networks need to be fully acknowledged when considering student learning in this context. This will be further explored in the final chapter of this thesis.

The data in this category identify that respondents recognised the impact of care on patients and clients and challenged philosophies and systems which they did not

perceive to meet patient/client need. However, several respondents acknowledged the potential challenges of realising their ideals in terms of professional roles, due to competing priorities and lack of resources. Several respondents in this study explained that they strived to develop equal relationships with patients and clients and recognise the potential power imbalance inherent in the professional role. These issues will be discussed in the next two categories which will explore the data in relation to professional relationships and understanding the patient's perspective.

3. Professional Relationships

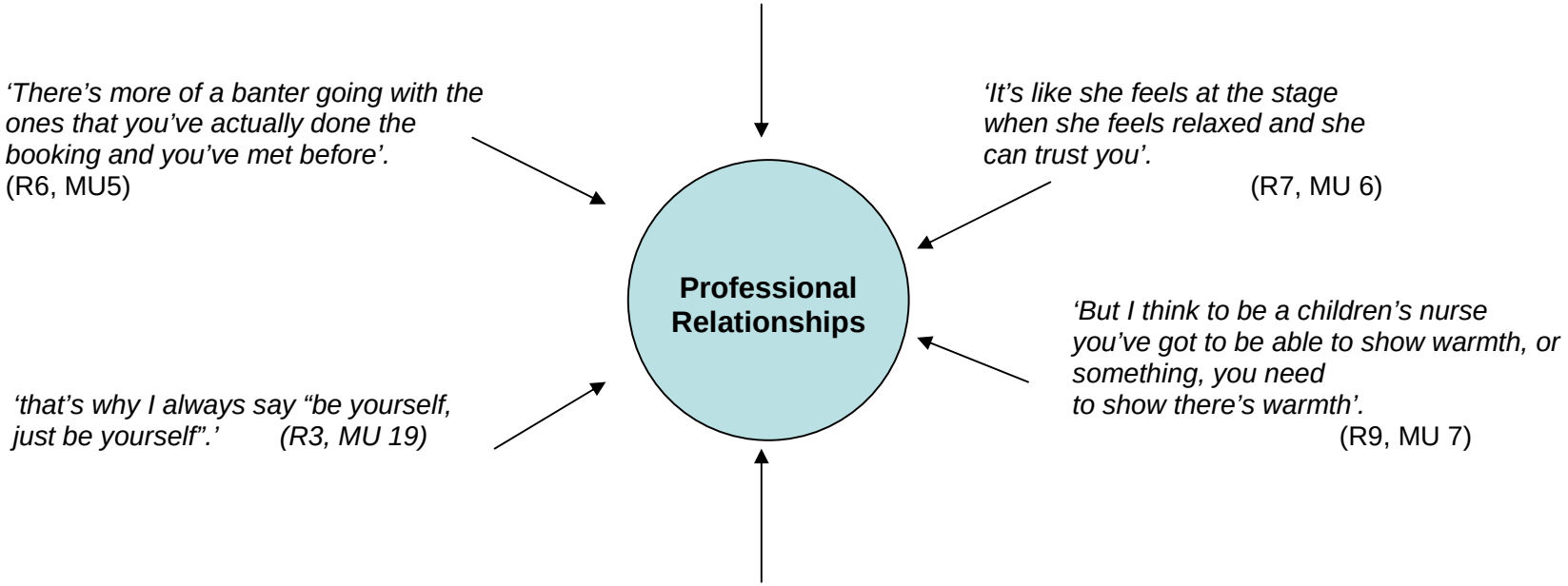
As highlighted in the previous section, professional relationships comprised the largest aspect of respondents' discussions during interviews and this is evident from the transcripts. Learning about professional relationships was present in all respondents' descriptions of patient stories and critical incidents and was the major focus of learning from positive and negative models in practice, which were presented in the previous chapter. This section will present more detail of the nature of those relationships, again using extracts from the data reported in respondents' own words, Diagram 8 below provides examples of some of the issues raised within this category.

Although the majority of respondents discuss communication as an important aspect of their professional programmes, it is apparent from the data that they all view this as part of relationship building, rather than as the development of specific communication skills. The following extracts from interviews with R3 and R6, both midwifery students, demonstrate the value they attach to relationship building. R6 reflects:

'So the women that I've booked, because the booking takes such a long time and it's quite personal, you do feel that you've already started to build a relationship with them. So the couple of times that you see them in ante-natal you build, you just, I mean even though its ante-natal you're only there for ten minutes. They've only got a ten minute appointment and you're checking that they're okay, you do the palpations and fetal heart. There's more of a banter going with the ones that you've actually done the booking and you've met before. There is more of a banter. And they do, I mean I feel if somebody comes in labour who I know from ante-natal you've already sort of like got a rapport with them. So you can automatically start giving them good care without having to ….all the getting to know each other thing……..because you already know that'. (R6, MU5)

Diagram 8: Examples from the Data to Illustrate Category 2.2 - Professional Relationships

'You have to (be affected when someone dies) if you are not, you get hard….you can't go round like a gibbering wreck all the time but ….'. *(R2, MU7)*



'I don't think it hurts for your patient to see that you're a human being sometimes'.
(R4, MU 7).

'Anybody can learn the skills, but it's your people skills really, to work on them really….. talking and listening more than anything'.
(R1, MU 16)

This view is reinforced by R3, who recognises that delivering a baby is not just about competence:

> *'You know, at the end of the day you can deliver a baby, and delivering a baby is delivering a baby, but it's everything that goes with it'.* (R3, MU6)

This category now will be discussed in relation to professional knowledge; nature of relationships; personal development; honesty and trust.

3.1 Professional Knowledge

R1 and R4 both recognise that skills are an essential professional attribute, but they both focus on the ability to communicate effectively in respect of professional roles:

> *'Well obviously I've got clinical skills and things like that. I've always thought I was pretty good at dealing with people anyway and I've learnt the main thing with nursing is good communication, with anything that you're doing nursing wise….it's an essential thing that you need to be a good nurse really'.* (R4, MU 3)

> *'Anybody can learn the skills, but it's your people skills really, to work on them really….. talking and listening more than anything'.* (R1, MU 16)

As stated in chapter two, there is a lack of consistency in definitions of the concept of professionalism. The literature indicates that professional behaviour includes technical ability, skills, professional knowledge, professional values, and ethical decision making (Asp and Fagerberg, 2002; Billay, Myrick, Luhanga and Yonge, 2007; Schon, 1991). Although skill development and behaviours are necessary to verify competence, it has been argued that this leads to a restricted view of proficiency (Norman, Watson, Murrells, Calman and Redfern 2002).

However, it was apparent from the data that respondents in this study focused on professional knowledge in terms of professional values and ethical decision making, rather than technical ability and skills. This does not support the findings of the literature reviewed in chapter one, which indicated that nursing, midwifery and social work education has become increasingly outcome focused in recent years. There has been a long standing debate, within professional education, as to the relative emphasis and values of competence and skills acquisition and of cognitive and affective development. The Nursing and Midwifery Council and General Social Care Council requirements for programmes leading to professional registration are prescriptive and outcome based, focusing largely on the assessment of competence (GSCC, 2002; NMC, 2004a, 2004b; TOPSS, 2002). However, the data from this study do not support the concern that professional programmes may become reductionist in nature and may lose their holistic focus (Kelly and Horder, 2001; Talbot, 2004). Rather, they indicate that, for these respondents, relationships are the main focus of their learning from patients and clients, in practice settings.

3.2 Nature of Relationships

Consistency of relationships was considered to be an important aspect of developing this professional relationship. For example, R7 concluded that:

> *'It's best for the woman, isn't it, if she knows you? It's like she feels at the stage when she feels relaxed and she can trust you. It's better for me because I'm not seeing strange women all the time, I'm seeing women that I've built up a good relationship with'.* (R7, MU6)

This view is congruent with the government agenda for women-centred care and continuity of contact with health professionals, as outlined in the National Service Framework for Children, Young People and Maternity Services (D.H., 2004d).

R6 and R3 also reflected that they felt more relaxed with women, during deliveries, when they had had the opportunity to develop effective relationships with them ante-natally:

> *'Yes on them, and on me as well, because I'm more relaxed. I mean everybody gets a little bit anxious when, well I presume everyone does when they're going to have a delivery. And I think if I know the person already, if I know the woman already then I'm calm as well.* (R6, MU6)

> *'To me it's all about communication and building up a rapport and that tells me how to care for somebody. If you haven't built up a rapport for somebody you find it hard, if you haven't got a good relationship with somebody and you try and care for them in labour it's horrendous. You*

can't talk about anything…..so I just think, that's why I always say "be yourself, just be yourself". (R3, MU 19.

It is interesting to note that R3 views the professional relationship in terms of being herself. This demonstrates that she values a humanistic approach to care and that she develops an equal relationship with patients; this view is supported by several other respondents. For example, R4 provides a detailed account of his experience of assisting a district nurse to care for a terminally ill woman and her family. He admires the way that she dealt with the situation but was upset in the car afterwards:

'You have to [be affected when someone dies] if you are not, you get hard… you can't go round like a gibbering wreck all the time but ….'. (R2, MU7)

R9 expresses her belief that children's nurses should demonstrate warmth in their relationships with children and their parents:

'Sometimes they do [open themselves up to children and parents]. Erm, others are very – I'm here to do a job and you know nothing about me, you don't even know my name. Sometimes I think that's, it's a children's ward at the end of the day, children open themselves up to us, and it's just, you're building up that relationship. If you've got a good relationship, you get on better and quicker…But I think to be a children's nurse you've got to be able to show warmth, or something, you need to show there's warmth, You can't be a cold slab, you know, you've got to – you can't be a stone'. (R9, MU7)

It is apparent, from the above examples, that respondents value the concept of authenticity in their relationships with patients and clients. This supports Barnett's (2007) argument that authenticity is a vital aspect of higher education, with students developing in terms of self as well as academic progression. He concludes that to develop this authenticity, students need to be given what he refers to as pedagogical space: "…. if we wish our students to fly, to become themselves, to take off, to take on the world, we have to let them go' (Barnett, 2007, p.70).

This philosophy will be further explored in chapter eight, in relation to the application of transformative learning theories to the phenomenon under investigation; that is, learning from patients and clients in practice settings.

3.3 Personal Development

The process of respondents' personal development is also evident in the data. For example, R7 describes how her conceptual framework changed over the course of her programme, in respect of the nature of the ideal professional relationship:

> *'…because you learn from your practice and I've probably learned from watching other midwives with women and watching their relationship and seeing how far to get involved and when to take a step back and things. Because when I first started all I wanted to do was just hug everybody and say "oh it's going to be OK, you're going to be alright, you're going to be fine!".* (R7, MU 10)

This example was also used in the previous chapter to illustrate R7's learning from role models and is included here as an example of the simultaneity of ontological and epistemological perspectives within the data.

Several respondents relate their past experiences to learning about appropriate professional relationships and being authentic in their communication with patients. For example, R2 and R4 described their own experiences of bereavement and explained how they applied their learning from these to developing effective relationships with patients and their relatives:

> *'I think I found it hard because my own grandmother died a few months previous, so at the time it was erm, a couple of times, I could draw comparisons between what the family was going through. I was there when she died, my grandmother, so erm…..so I could see the comparisons between the two of them'.* (R2, MU7*)*

> *'Well, you can't not have emotions, because then you can empathise with the people you're looking after. You have to keep them in check to a certain degree. I don't think it hurts for your patient to see that you're a human being sometimes. I don't think it hurts your family to see that things affect you. At the same time you've got to remain calm and, and controlled to a certain degree. I have approached people before, not long after my father died, there was a family in a similar situation and I spoke and said "I've just been through a similar thing and I understand what you're going through" and the daughter came to me afterwards and she said "I really appreciated you saying that to me. You know it helped."*

You know, it's things like that isn't I'. (R4, MU7)

R5 described his experience of working with elderly people and of caring for his grandmother and he perceives that this helped him to develop better relationships with elderly patients than many of his colleagues:

'I mean especially the young students and that is there first contact with the elderly and what they're learning from the first year. Sometimes, because they've never related to the elderly before, I find - they find it quite hard. They don't spend much time with them because they don't know how to deal with them….'. (R5, MU4)

3.4 Honesty and Trust

The data provide evidence that all respondents recognised the importance of being honest with patients and clients in order to develop trust in their relationships. For example, R1 reports a discussion with a patient who valued the fact that she kept her promises to him. He had previous experience of nurses saying they would come back to him and then not returning; this had left a lasting impression on him. R1 reports that:

'I had one patient, one patient and they actually said to me that they'd been on another ward and then they were transferred on to my ward. And they were saying things like – "you know I like you you're nice, if you say you're going to do something you make sure that you do it". And they recall that, when they were first admitted to the hospital, they had a nurse

that came to them and said "oh I'm going to take care of you" and then theydidn't see them for the rest of the shift at all. They were transferred over, but that had left an impression with that patient. You know, he thought that that nurse, he was quite pleased that that nurse was going to look after him, and then he was all disappointed that she wasn't there. So, since that conversation with the patient, what I say to a patient I always make sure that I do…. I learnt, well say what you mean, what you're going to do'. (R1, MU 5)

'Yes, I don't make promises to them. You know if they ask me something Isay "well I'll try and find that out". If I can't I always go back and say "look I couldn't find that out but so and so will come and talk to you about it"'.

(R1, MU7)

R11 describes an experience with a family involved in child protection issues and she developed an honest, non-judgemental, trusting relationship with the parents:

'My communication skills are really good and I think I gave them the opportunity to build up a relationship with me, a professional relationship but, in the sense that they could trust me….and every time I wrote something, I would show it them, before a meeting, because I just feel, I want them to see, you know thinking, being overwhelmed by a report everyone was sitting….so I always made a point of ….show them this report and I would say "look you know this is the report and these are the reasons why, erm, the concerns" and they would say "we don't agree" and, you know……..I would say "I'm really sorry but I have to put this down and I will say it in the meetings" –

express my concerns, but in a way where I wouldn't be intimidating them and they knew what I was going to expect. I didn't want to put anybody, to put them on the spot. Because it's awful being in this situation anyway and when it's to do with their family, I think they've got a right to know what, erm, you know – what the plan is…'. (R11, MU7)

It is evident from the data that professional relationships were the major focus of learning for students within the context of learning from patients and clients in practice settings. Respondents articulated the nature of professional relationships which they had experienced themselves, and which they had observed in both positive and negative role models. In the experiences discussed above, respondents demonstrated respect and were non-judgemental in their approaches to patients and clients. They recognised the benefits, both to patients/clients and themselves, of developing an effective relationship and consciously worked to achieve this. Authenticity was a concept which was recognised and valued by the majority of respondents in this study.

As discussed in the previous chapter, this learning from patients and clients was reported to be largely '*ad hoc'* and not facilitated by mentors or practice teachers. It is interesting to note that none of the students referred to their learning from patient experience in terms of specific learning outcomes. Their learning was of the informal, tacit type as described by Eraut (1994; 2004) rather than the outcomes and competencies prescribed by professional bodies. The data indicate that students recognised their learning, from these experiences, and that this learning led to changed conceptual perspectives in relation to the nature of professional relationships. However, it is important to remember that the focus of this study was student learning from patients and clients and, therefore, these conclusions are specific to the context of this research.

4. Understanding the Patient/Client Perspective

This is an aspect of professional relationships which was identified as a distinct category, because it clearly demonstrates respondents' recognition of the importance of understanding the situation from the patients'/clients' perspectives (as illustrated in Diagram 9 below). Many of the respondents challenged systems of care and the attitudes of other professionals and then advocated for the patient to overcome these. Respondents were also able to articulate their own development, in terms of their ability to act as advocates through the programme, as their knowledge and confidence increased. This category will be discussed in relation to listening to patients and clients; correcting misconceptions and advocacy.

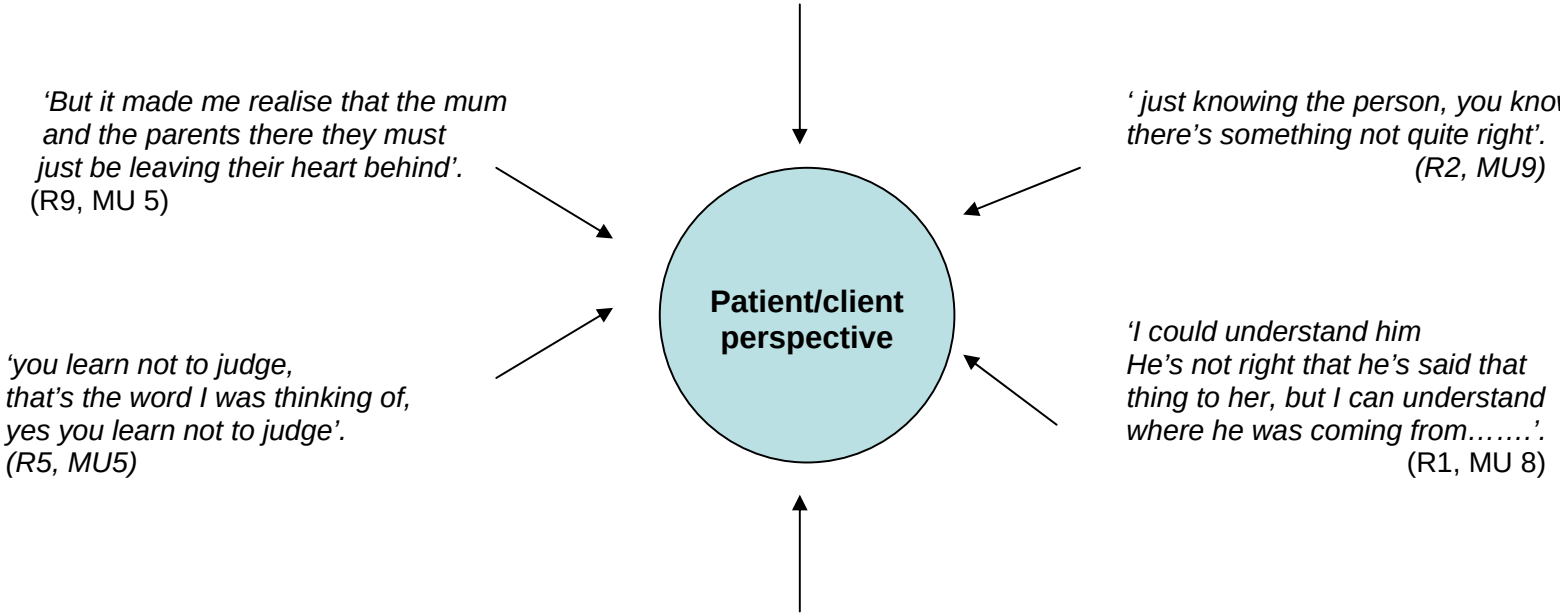
The data indicate that respondents also recognised the potential power imbalance which is inherent in professional relationships. For example, R11 acknowledges the potential power which social workers have when interacting with clients and consciously avoids using this inappropriately:

> *'We had a duty and we had some kind of, of power, as well ….and because you didn't want to, sort of, use that it a negative way – I tried to be positive'.* (R11, MU 14)

Diagram 9: Examples from the Data to Illustrate Category 2.3 - Patient/Client Perspective

'A few patients stick in my mind. The main thing I've learnt from them is that they are people, they are human beings'.
(R4, MU 11)

'I think, first of all I try to get to know a person, so I'm not going in with any, sort of, preconceived thoughts or ideas'.
(R12, MU 7)



'Yes, I was being autonomous and I stood up for the woman and said "actually she doesn't want that". Because the woman too, she didn't have the guts to stand up to the doctor'. (R3, MU13)

4.1. Listening to Patients and Clients

The importance of understanding clients' perspectives in order to meet their individual needs is explained by R12, who accessed as much information as possible about a new referral to the social work team and then developed an effective relationship with the woman. This enabled her to understand the woman's isolation and to recognise that the woman had considerable insight into her own illness:

> *'I think, first of all I try to get to know a person, so I'm not going in with any, sort of, preconceived thoughts or ideas. Erm, she was quite mentally ill, and you know, just her look – you could see that she was mentally ill and erm, I didn't want that to get in the way. So, I do try very hard to let the person come out, if you like and so it was spending the first few times just listening, just basically listening and for me to try to get an understanding of her perspective on things. Which she did very well, she had tremendous insight into her own experiences, into the way other people experience her and either understand her or not'.* (R12, MU7)

R1 gives an example, which she does not perceive to be of major importance, but which demonstrates the importance of understanding why a patient was not taking his medication. She attributes her ability to get to know people to her maturity and life experience:

> *'They wouldn't be major things, I mean, you know, "I don't really take the medication". You know, you delve a bit deeper and see why they're not taking it, and different things, like I can't swallow it, I don't know, I think it's*

being more mature. That's not the whole answer, it might be part of it. Patients have said that though - they don't like these young uns. You know they say "I'd much sooner see you because you're older and you understand me better". I know as well, being of a certain age and that sort of thing, I don't know. I don't know what it is'. (R1, MU12)

R9 describes her experience on a children's ward and reflects that although tonsillectomy may be relatively minor surgery, which is considered routine by professionals, it is a major event for the child's parents. She recognises the emotional impact on them and the anxiety which this causes:

'Sometimes it's quite hard because like tonsillectomies - on Thursdays the ward's full of kids having their tonsils out and I was walking this patient up to the theatre - just part of our daily thing. You know, on Thursday, you go back and to, to theatre. But it made me realise that the mum and the parents there they must just be leaving their heart behind. And again that's important. "He's only going for a tonsillectomy – what are you getting so upset about?"'.

(R9, MU5)

It is interesting to note the student's use of the term 'tonsillectomies' to describe children who were admitted for the procedure. This is consistent with the socialisation and labeling of patients discussed earlier, but totally contrary to the government agenda for patient-centred care. However, the context of this students' response, as a whole, indicates that she is child centred in her approach and this term may be an indication of the ward culture, rather than of the students' attitude.

R4 reflected on his experience of caring for an elderly man with dementia. R4 recognised that, although he had communication problems, the patient could understand far more than the health care assistants realised:

> *'A few patients stick in my mind. The main thing I've learnt from them is that they are people, they are human beings. My first placement, the one that stuck in my mind, very intelligent gentleman but he had some sort of erm, dementia, I don't know, Alzheimers, something was going on, and everybody, a lot of the HCAs sort of treated him as if he didn't know what was going on, but he did though. He was very aware what was going on, but just couldn't communicate very well'.* (R4, MU11)

R4 explains that the patient's wife was away on holiday and that he and the health care assistants took him back to his own flat to telephone her:

> *'He wanted to stay in his flat, he did not want to go and, erm, what was awful was that he had to go and they had to almost force him out of his flat - which I wasn't very impressed with. What I learnt was, obviously, people had perceived, they had got all these ideas about him what he was like. And they hadn't got a clue. The people that are supposed to be caring about him hadn't even got a clue….. One of the HCAs went "oh look he's smiling!" Like he was an animal in a zoo almost, and his face just went (facial expression), and that was it'* (R4, MU11)

R4 was distressed about the way that the health care assistants treated this man. He reflects that they did not show him respect and continues to explain how he

communicated effectively with the patient and understood why he was reluctant to eat in the dining room:

> *'Eating, as far as eating was concerned, he wouldn't eat but he had been seated with three or four residents that didn't eat in a very nice manner for various reasons. I said to him" would you like to go and sit over there to eat?"- took him to a place with his back to them and he ate the whole meal. So you see…..that's the main thing I think. I've learnt how to read signals from them perhaps – I don't know'.* (R4, MU 11)

R2 provides an example of the individual nature of patients' experiences and presentation of pain and that recognises that their needs cannot be assessed by their condition. He describes his experience in relation to pain assessment:

> *'….you would have two patients who had got exactly the same conditions, both obviously would be in a lot of pain……wasn't really saying very much but her body language was giving away that she was actually still in pain and the other one was very vocal…….just knowing the person, you know there's something not quite right'.* (R2, MU9)

4.2. Correcting Misconceptions

All respondents reported experiences in which they consciously tried to understand the patient's perspective and the data includes several examples of where students corrected other professionals' perceptions of difficult or

unpopular patients. For example, R5 describes his experience of caring for an elderly man who was admitted to hospital in an unkempt state:

> *'Erm, I think, to do what, you know toleration, you know, you learn to tolerate other people's problem. Like that smell and, not being, you learn not to judge, that's the word I was thinking of, yes you learn not to judge'.* (R5, MU5)

R1 spent time with a man who communicated inappropriately with a nurse who was pregnant:

> *'I could understand him. He's not right that he's said that thing to her. But I can understand where he was coming from…….and he just said that he felt, he didn't feel sad that he said it to her but he just felt that everything was against him. And he was sort of picking out anybody and everybody'.* (R1, MU8)

R4 reports that he had observed negative role models in relation to the ways in which professionals had displayed judgemental attitudes towards patients:

> *'…..I've come across people who treat others as if they're just a piece of meat, I…you need to step into somebody's shoes'.* (R4, MU 4)

He then describes an experience when he communicated effectively with an elderly man who was considered to be difficult by colleagues and, by treating him with respect and dignity, was able to correct their misconceptions:

> *'I've been in situations where, we've been in handover, not on this particular placement, and they've moaned about a patient, about them being miserable or perhaps slightly aggressive, or just, whatever. And I think we, as nurses, should be able to take a step back and think "well why are they being like that?"'.* (R4, MU 5)

These extracts from the data are in keeping with the seminal work of Stockwell (1972) on the unpopular patient. She reported that patients were evaluated by nurses in terms of social worth and that popular patients were given more time and attention. It is surprising that thirty years later, this is still occurring and is in direct opposition to the government agenda for patient/client centred care discussed earlier. However, it is apparent that the students in this study did not share this view. Indeed, they actively tried to understand the patients' and clients' perspectives and, in many cases, acted as their advocates. Johnson and Webb (1995) reported on a study to explore the evaluative labels used by professionals and concluded that the process of social judgement is far more complex than originally thought. This is illustrated by the extracts from the nursing students above and by R12, a social work student, who reports her experience of working closely with a client with mental health problems:

> *'I think, first of all I try to get to know a person, so I'm not going in with any sort of, preconceived thoughts or ideas. Erm, she was quite mentally ill, and you know, just her look – you could see that she was mentally ill and erm, I didn't want that to get in the way. So, I do try very hard to let the person come out, if you like and so it was spending the first few times just listening, just basically listening and for me to try to get an understanding*

of her perspective on things. Which she did very well, she had tremendous insight into her own experiences, into the way other people experience her and either understand her or not. You know, the fear that people have. She talked about all that reallyopenly, it was just so, I don't know, I saw her as - she was a person. There was no qualities of life really, she, her main experience is she's constantly suicidal, she has bipolar, erm, but she's always in this frame of mind that, she's conscious all the time that, just with a click of the fingers, she could feel like just committing suicide and has made attempts, even at one point, parking her car on the railway tracks. I know. But she knows often, and she knows when she's going into a decline, erm, and so she just locks herself away, so nobody can report her, because other behaviours have involved her going out in a night dress to post a letter, putting post it notes round neighbours doors. You know and they just couldn't accept that she didn't care basically "so what if I'm out in my nightdress – what harm am I doing?" You know?..... but she couldn't erm, she couldn't let anybody, take the chance of ringing social services, the police or whatever. So where she would …because when she gets quite manic she can't sleep, erm, so she spends all night sitting up organising her life, because she goes into these real big spend things, where she spends all her money. So now, she pays all her insurances a year in advance, she pays her bills a year in advance, so she that never runs out of money. Erm, she writes her Christmas cards three years in advance, erm, and just things that will keep her occupied…… through her manic times, you know, so she's not play music for the neighbours to complain…she's just you know, really taking car now, not to get into hospital again. (R12, MU7)

4.3. Advocacy

The data demonstrate a range of levels of advocacy. All respondents provided examples of experiences in which they had developed effective relationships with patients and clients and gained an understanding of their perspective. Several respondents related this to other professionals inappropriately making judgements about patients/clients, which they were then able to correct. The data also indicate that some students were able to act as advocates for patients and clients with other professionals. The concept of advocacy was evident in all interviews, but at different levels. The more active approach was demonstrated by R10 who describes a difficult situation in which she developed effective relationships with a woman with dementia and her daughter. She developed effective relationships with both and managed to understand both of their perspectives; this enabled her to act as an advocate to arrange appropriate care for the woman and also helped her daughter to access support:

> *'To work on communication, to find out exactly what she needed and how much was being influenced by the daughter saying "you shouldn't be in this environment"'.* (R10, MU 11)

> *' …and I worked with the daughter as well, looking into getting direct payments'.* (R10, MU12)

R7 also describes an experience involving a patient's relative. In this case, she was caring for a woman in labour whose partner was unsupportive:

> *'I mean, sometimes you have women who are just completely, just*

don't want their husbands……anything to do with them and you think "oh well that's fair enough" but then she relies on you a lot for support'.

(R7, MU8)

Several respondents describe their role as advocates for patients with other professionals. For example, following an unexpected neonatal death R3 reports:

'Yes, I was being autonomous and I stood up for the woman and said "actually she doesn't want that". Because the woman too, she didn't have the guts to stand up to the doctor'. (R3, MU13)

The extract from the interview, presented in chapter five as an example of the process of data analysis, demonstrated how R8 was annoyed with a doctor who had not communicated effectively with a woman who had been diagnosed with breast cancer. She explained that she acted as an advocate for her:

'And I said "I don't think Mrs X has been informed of this doctor". I was, I could have hit him round the head I could! I mean, you know, he probably, just gets blasé I suppose'. (R8, MU 24)

In another case, R8 compares the experience of elderly patients within an acute NHS Trust to that of learning disability clients, in relation to their access to advocacy services. She describes the distress felt by an elderly woman who was being discharged to a nursing home with little choice:

'Especially you know if they've got no family and it's the whole, you know,

so I suppose, because I felt because I'd worked in learning disability for years and we'd always used an advocacy service whereas for learning disability that's something that's been going for a long time. But there isn't that much for people in the general population ……..Erm, so that they've got somebody that can stick up on their behalf in any meetings or anything or alongside them. Whereas an elderly person that's on a general ward that's confused has probably got the same needs but they haven't got that service there'. (R8, MU6)

The following extract provides an example of advocacy in a social services setting:

'And I thought the outreach coordinator, who was processing her eligibility for services, when I'd made the assessment, and I'm sure when I walked away they were laughing at me because "you're joking", you know, "social support, emotional support, what's that?- kind of thing. But I kept pressing and I kept going to see him, just pressing her needs for it really. Ok it might not be a priority in sort of my experience and whatever, but for her it is a priority, and eventually we were able to kind of coordinate a meeting where he came with me to meet her, and this did upset me a bit, because once he'd met her he understood straight away why she needed that, but from the paperwork'. (R12, MU9)

R9 is aware of her own development, throughout her programme, in terms of her ability to advocate for children. She intervened with a doctor to ensure that a child received the appropriate plaster for a broken arm, she explains that:

'I think the third year definitely you become a lot more confident and that, because you have more responsibility in your third year and you've got to be an advocate for the child'. (R9, MU 16)

The earlier discussion, in relation to the quality of services provided for patients and clients, raised issues in respect of inter-professional working and communication. The extracts from the data presented above also support the view that conflicting power relationships challenge effective inter-professional working (Rolls et al., 2002). These data are consistent with the view that, in these cases, doctors have maintained their traditional dominance in health care (Blane, 1997; Waddie, 2007).

This power imbalance, which is demonstrated in several of the experiences above, is not consistent with the patient centred ethos of the extensive Department of Health policies published during the past decade. The notion of expert patients (Chief Medical Officer, 2001) challenges the traditional role of health professionals in relation to their knowledge. The influence of self-help and self-diagnosis, partly due to increased access to information via the internet, has also blurred the boundaries in relation to the ownership of professional knowledge (Wilkinson, 2007). Wilkinson advises that the role of health professionals is that of enablers, to assist decision making and choice, rather than seeing patients as a challenge to professional expertise. Whilst students in this study demonstrated an enabling approach, this was not evident in the behaviour of a number of other professionals in the examples reported above. Indeed, several of the examples above support Ilich's (1977; 1995) influential writings in relation to health care, in which he describes the social control of expertise to raise the status and privileges afforded to professionals . Illich provides examples of the medicalisation of life, including pregnancy, ageing and death, which were originally considered to be natural processes.

This process of medicalisation, he argues, has reduced people's ability to act in a personal and autonomous way and to manage their own health. He argues that professionals use their specialist knowledge to first define and then to treat the problem: "you will be better because I, the professional, know better" (Illich, 1977, p.83).

Despite the far reaching changes in health and social care policy, Sweeney (2006) contends that the dominant discourse in medicine is still based on a rationalist positivist ontology, in which the body is viewed as a machine. He suggests that evidence-based medicine has reinforced this objectivity, leading to a doctor-centred approach, in which the subjective view of the patient is undervalued. Friedson (1988) suggests that the doctor-patient relationship is characterised by conflict rather than harmony because of the different perspectives they hold. He contends that the patient is personally involved with the illness and assesses its significance in terms of social and psychological impact, including the implications for his/her life as a whole. However, doctors view the patient's condition in a scientific manner and evaluate its significance according to clinical criteria. Frank (1997) also discusses the power inherent in professional relationships. He argues that the functionalist view of illness led to individuals handing over control to doctors and becoming compliant. Frank presents the post-modern perspective that patients need to reclaim responsibility for their own illnesses and to tell their own stories. This view is consistent with the researcher's own philosophical stance in relation to health and social care, which was influenced by the seminal work of Illich (1977; 1995) which advocated equal relationships between professionals and patients.

However, these findings provide evidence that respondents in this study are aware of potential power imbalances within relationships and actively try to conform to their enabling function, and to listen to patients' stories to gain an understanding of their

perspectives of the situation. The students who were interviewed in this study, seemed to agree with the ethos of government policies which promote active patient involvement in care. However, some of the experiences reported by them indicate that there are still many challenges, in respect of this power imbalance between patients and other professionals.

5. Conclusion to Chapter

This chapter has presented the findings of the research study in relation to the second theme which was extrapolated from the data; that is, the 'Nature of Learning' from patients and clients in practice settings. The data were considered with reference to health and social care policy and to the literature relating to professional education, which were presented in chapter one.

All respondents described their learning from critical incidents, patient stories, interactions with patients and clients and observing role models, from which they developed their own philosophies of professional ideals and professional roles, including the nature of effective relationships and understanding patients'/clients' perspectives. As discussed in chapter one, there is a lack of consistency in definitions of the concept of professionalism and concern that professional programmes are becoming increasing competence focused in their approaches (Norman et al., 2002). However, the data from this study demonstrate that students' learning from patients and clients focused on professional knowledge in terms of professional relationships and values, rather than on technical ability and skills. As identified in the previous chapter, the findings from this study are consistent with the literature which suggests that learning from patients and

clients is a valuable strategy to promote student learning, but in this case without active facilitation by mentors, practice teachers or lecturers.

The data indicate that the students interviewed in this study had developed philosophies of care which were consistent with the policies reviewed in chapter one, in relation to the modernisation agenda for health and social care. These policies involve the active involvement of patients and clients in all aspects of health and social care planning, delivery and evaluation. They also promote patient centred care, with increased autonomy, independence and individual decision making. However, a number of experiences were reported which did not conform to this agenda and students recognised that these were inappropriate. All respondents recognised the impact of care on patients and clients and many challenged philosophies and systems which they did not perceive to meet patient need. The data indicate that the students involved in this study viewed professional ideals in terms of the quality of care experienced by patients and clients and of professional roles. Several respondents acknowledged the potential challenges of realising their ideals in terms of professional roles, due to competing priorities and lack of resources. All respondents demonstrated a non-judgemental approach to patients and clients and were authentic in their relationships with them.

This chapter presented several examples in which students learned from role models; they valued humanistic, authentic relationships between professionals and patients/clients, and recognised the inappropriate use of professional power. However, the data provides a range of examples in which the students observed other professionals and recognised the potential power imbalance inherent in the professional role. This is consistent with the literature reviewed, which identified that, despite the extensive rhetoric promoting active patient involvement, many professionals have

retained their original roles in respect of expert power. There are also examples in the data which indicate that there are continued power imbalances in relation to the social control of expertise as discussed by Illich (1976; 1977) and the different perspectives demonstrated by patients and doctors (Friedson, 1988). The data suggest that students, in this study, listened to and valued patients'/clients' perspectives of their situations and provided opportunities for them to tell their stories and to maintain responsibility for their own illnesses (Frank, 1997). This will be explored in further detail in the following chapter which will consider the holistic approach offered by complexity theory, with its recognition of alternative forms of knowledge, relationships and interconnected networks.

Understanding patients' and clients' perspectives was identified as a distinct category; the data clearly demonstrates the students' recognition of the importance of this. All respondents provided examples of experiences in which they had developed effective relationships with patients and clients and gained an understanding of their perspectives. Many of the respondents challenged systems of care or the attitudes of other professionals and advocated for the patient to overcome these. The data demonstrates a range of advocacy approaches. For example, several respondents related this to other professionals inappropriately making judgements about patients and clients, which they were then able to correct. The data also includes examples of situations in which students were able to act as advocates for patients and clients with other professionals to challenge practice. Respondents were able to articulate their own development, in terms of their ability to act as advocates through the programme, as their knowledge and confidence increased.

The policies reviewed in chapter one also highlighted the importance of integrated working across a range of health and social care organisations, with a corresponding requirement for inter-professional working and learning. The data in this study demonstrate that, in some cases, this is not effective and they support the literature which suggests that barriers in terms of organisational and professional differences still exist (Glasby, 2003; Richardson and Asthana, 2006).

The experiences reported in the data are mainly negative in their focus, despite prompts from the interviewer that these could be either positive or negative. The examples reported above are not claimed to be representative of the experiences of students overall, but they do provide insight that, in a range of situations, patient centred, integrated care did not happen in practice. They also provide evidence that these students were aware of the issues related to this and, in several cases, strived to overcome the task orientated, professional dominated approaches they encountered. The data demonstrate that these students adopted the patient/client centred approach to care advocated in government and professional policy. However, there are a number of examples which indicate that systems of care in practice do not always conform to this ethos.

The researcher continued to develop her own conceptual perspective as this thesis developed. As in the previous chapter, this included consideration of complexity theory in relation to the data presented in this theme. It was apparent, from the reviews of literature in the first three chapters of this thesis, that complexity theory is applicable to the diverse range of placements in which students complete their practice experience. The researcher concluded that these are consistent with the concept of complex adaptive systems and that professional education programmes should consider

alternative approaches to learning. This chapter supports these conclusions – the data demonstrates the complex nature of learning in the context of this study.

Students described their learning in relation to professional ideals and relationships and it was evident that this was influenced by a wide range of agents within the practice setting. In contrast to the traditional reductionist approach of scientific theories, complexity theory focuses on whole systems and on the networks and relationships of the agents within these. This is appropriate to the current policy drivers in terms of the changes to service delivery and the need to prepare professionals to work effectively in ever changing health and social care organisations. The data indicate that the complexity of interactions within practice areas was not formally recognised by mentors or practice teachers. This will be further developed in the following chapter, in which the researcher will propose strategies to harness learning from the complexity of practice placements.

The data within this theme illustrates respondents' understanding of patients' and clients' perspectives, which demonstrates a holistic approach in relation to their perceptions of both care and learning. Numerous examples were presented, in which students learned from alternative forms of knowledge (for example patient stories) which related largely to professional ideals and relationships. Complexity theory is holistic, it values both competence and alternative forms of knowledge and recognises the importance of relationships and interconnected networks, which are typical features of health and social care organisations. This approach is consistent with the data presented above and is relevant to the policy drivers for increased public involvement and autonomy in service delivery.

The two discussion chapters have demonstrated that respondents' ways of learning and the nature of that learning were inextricably linked. Complexity theory acknowledges this simultaneity and provides a framework to integrate the knower and knowing, recognising the importance of both ontological and epistemological perspectives. The final chapter of this thesis will explore the theoretical basis of student learning in practice settings in the light of the findings of this study. It will consider the relevance of contemporary theories and complexity theory to the data obtained in this study and will integrate these to develop a framework to inform practice. It is important to recognise that these findings are context specific and any implications for practice will be related to the specific focus of this research; that is, learning from patients and clients in practice settings.

Chapter 8: Conclusion and Theoretical Framework

1. Introduction to Chapter

This is the final chapter of this thesis, which has outlined an inductive study that explored nursing, midwifery and social work students' experiences of learning from patients and clients during practice placements within their programmes of study. This chapter will include an overview of the development of the thesis and will synthesise its conclusions into a theoretical framework to explain the phenomenon of learning from patients and clients in practice settings.

It is evident that the contemporary theories of andragogy, experiential, social learning, reflective and transformative learning are relevant to the context of this thesis. The new knowledge obtained in this research - that powerful learning experiences were reported following unplanned, informal learning opportunities involving interactions with patients and clients - was not sufficiently explained by these theories. This led the researcher to further explore complexity theory, in relation to the data obtained, and to incorporate this into the theoretical framework, to complement the contemporary theories which currently underpin professional education.

The thesis is situated within the context of professional education in health and social care and it arose from the researcher's interest in professional education, specifically practice based learning. The enquiry was influenced by the researcher's own philosophy in relation to professional education, which values equal relationships and mutual learning, with the empowerment of students. This was illustrated by the following quote in the introduction to this thesis: "The role of the educator is not to "fill" the

educatee with “knowledge”, technical or otherwise. It is rather to attempt to move towards a new way of thinking in both educator and educatee, through the dialogical relationships between both” (Freire, 2005, p.112).

The research approach of descriptive phenomenology which underpins this enquiry is consistent with this philosophy of valuing and empowering students. Giorgi argues that: “the researcher may know theories and the literature, but he or she does not know the relevant dimensions of the concrete experience being reported by a participant” (Giorgi, 2006, p.10). This quotation was considered to be directly relevant to the context of this thesis; the researcher has extensive experience of leading professional education programmes and extended her theoretical knowledge, whilst undertaking the PhD process, by critically reviewing relevant literature. The quotation is consistent with the researcher’s philosophical stance that students’ knowledge and experience should be recognised and valued in the education system.

The researcher was also influenced by the philosophy of higher education proposed by Barnett (2007). This philosophy emphasises the ontological as well as the epistemological perspectives of education and their importance in a students’ will and motivation to learn. Extensive reading and discussion around complexity theory, in the latter stages of the development of this thesis, suggested that this was highly relevant to the context of health and social care organisations and to professional education programmes. The researcher concluded that the inclusion of complexity theory would complement the contemporary theories which currently underpin professional education, to provide a framework which values the empowerment of students, but also incorporates the competencies necessary to ensure public protection.

The researcher's own conceptual framework, relating to the facilitation of learning in practice settings, altered during the development of the thesis. Her original stance - that all learning should be actively facilitated by mentors, practice teachers and lecturers - was challenged by the findings of this enquiry. By the end of the PhD process, the researcher believed that, rather than trying to control learning, the role of the educator is to develop an enabling infrastructure to create the conditions for learning.

2. Overview of Thesis

It was evident from the review of policies at the start of this thesis, that education programmes need to prepare health and social care professionals for a rapidly changing environment, which involves inter-agency and inter-professional working, with an emphasis on community based, integrated service delivery. Programmes need to focus on patients and clients as the central tenets of care and to ensure their representation in curriculum design, delivery and evaluation. The complexities of professional education were discussed, with consideration of inter-professional learning and the potential conflicts between university and practice based experience. It is apparent that the requirements for professional registration create tensions in programmes which aim to empower students, to develop cognitive skills and to achieve specified competencies.

The literature reviewed in chapter two confirmed the importance of practice learning and the vital role of mentors and practice teachers in promoting that learning. It is evident that a range of individuals are involved in facilitating student learning for, in and from practice experience, including lecturers, practice teachers, mentors and other members of the practice team. Although the majority of research comprised small scale studies,

these provided evidence of the complexity of practice experiences and of the importance of relationships in the learning process.

The literature reviewed in chapter three demonstrates limited empirical evidence to support the involvement of patients and clients in nursing, midwifery and social work education. However, the published literature does add to the growing body of knowledge in this area; it demonstrates widespread support for the involvement of patients and clients in professional education programmes. It is apparent that there is currently no clear definition of partnership and the studies reviewed demonstrate a range of approaches, largely at the lower end of the continuum of engagement.

A range of research approaches was explored in relation to their ontological, epistemological and methodological stances and these were applied to the aims and research questions of this enquiry. The researcher concluded that descriptive phenomenology was the most appropriate to explore the phenomenon of learning from patients and clients in practice settings, both as an underpinning philosophy and as a research approach. Giorgi's descriptive phenomenological research method (1989b; 2000c) using unstructured, conversational interviews, was therefore used in this study. The data analysis process described by Giorgi (1989b; 2000c) was applied rigorously to the data to ensure the quality of the study. The ethical implications of the research were an important consideration in this study and the researcher demonstrated adherence to the ethical criteria of beneficence, avoidance of malificence, equal opportunity, informed consent and technical competence (RCN, 2004).

The data from this study identified that ways of knowing included experiential learning, reflection on critical incidents, learning from patients' stories and role modeling.

Professional education is multi-faceted, due to the complexity of professional and organisational cultures, which give rise to potential conflict and different theoretical bases (Eraut, 2000). As previously discussed, the modernisation of health and social care has led to changes in the education of health and social care professionals, which currently adopts a competence based approach, whist still claiming to be underpinned by andragogical, student centred learning theories (Dick et al., 2002). Eraut's (1994) influential work on professional learning is widely acknowledged in the literature and he argued that personal knowledge, based on subjective experience, memories and past experience, is essential to achieve professional competence. The data in this research demonstrated that, in the context of learning from patients and clients in practice settings, subjectivity, interaction, emergence and personal knowledge were of prime importance to the students. This research also indicates that the transformative learning reported by students often occurred during unplanned learning opportunities. This is consistent with Illich's influential work 'Deschooling Society' (1971) in which he argued that most learning takes place outside formal settings, and with Barnett's (2007) notion of pedagogical space. This concept will be further developed later in this chapter.

The data from this study support the contention that practice experience is a vital aspect of nursing, midwifery and social work programmes and that mentors and practice teachers have an important role in student support. The literature indicates that the complexity of practice learning requires a planned, co-ordinated approach. However, respondents in this study provide numerous examples of transformative learning experiences, relating to interactions with patients and clients, which occurred without active facilitation. These findings are not consistent with the existing body of literature in relation to learning in practice, and this prompted the researcher to challenge the prevailing assumption that all learning in practice should be actively facilitated.

The findings are consistent with the literature reviewed in respect of learning from patients and clients, which proposes that this is a valuable strategy to promote student learning. The literature discussed refers largely to patients' and clients' involvement in university classrooms, with very little emphasis given to learning from patients and clients in practice settings. However, the data in this study provide evidence that all of the respondents accessed opportunities, during their practice placements, to learn from a range of individual patients and clients and that they used this knowledge to influence their practice.

The research data did not support concerns expressed in the literature that professional programmes are becoming increasingly competence focused in their approaches. Respondents clearly articulated their own philosophies of care, which were consistent with patient/client centred care, autonomy, independence and individual decision making. Students reported that their learning from patients and clients focused on professional knowledge, in terms of professional relationships and values, rather than on technical ability and skills. Professional ideals were reported in terms of the quality of care experienced by patients and clients and the nature of professional roles. All respondents recognised the impact of care on patients and clients and many reported critical incidents which led them to challenge philosophies and systems which they perceived did not meet patient/client need.

The data also provide a number of examples of experiences in which students learned from the subjective and emotional perspectives presented by patients and clients themselves. Whilst there is recognition in the literature of the value of this for patients, the educational value to students has not been widely recognised in health and social

care education. Respondents described a range of experiences, in which they developed effective relationships with patients and clients and strived to understand their perspectives. Chapter six presented several examples in which students learned from role models: they valued humanistic, authentic relationships between professionals and patients/clients and recognised the inappropriate use of professional power. These examples of negative role modeling demonstrated that, despite the extensive rhetoric promoting active patient involvement, many professionals have retained their original roles in respect of expert power. The data suggest that students in this study recognised when professionals were acting inappropriately and they both listened to, and valued, patients/clients' own perspectives of their situations. Students also reported a range of advocacy approaches in relation to challenging systems of care or the attitudes of other professionals and articulated their own development, in terms of their ability to act as advocates throughout the programme, as their knowledge and confidence increased.

This concluding chapter will continue with the application of the contemporary theories of andragogy, experiential, social learning, reflective and transformative learning and the evolving theory of complexity to the data. The researcher will develop a theoretical framework, incorporating these theories, to explain the phenomenon of learning from patients and clients in practice settings. By contributing to a deeper understanding of students' experiences of learning from patients and clients in practice settings, the thesis will thereby add to the existing body of knowledge in this field.

3. Application of Contemporary Learning Theories to the Data

The contemporary theories of particular relevance to the research data were identified as andragogy, social learning, experiential, reflective and transformative learning theories.

The data do not explicitly relate to behavioural or cognitive theories, but this is probably because of the specific focus of this research on learning from patients and clients. However, it is acknowledged that these theories remain relevant to other aspects of learning in practice settings, for example skills development and the integration of theory and practice.

Students in this study demonstrated many of the classic features of andragogy. They were self-directed in their learning; integrated past experience into their learning; valued experiential learning; reported immediacy of application and were problem centred in their approach to learning (Knowles, 1990). That students were self-directed in their learning was very evident, indeed the data indicate that the most powerful learning experiences reported in this study were not facilitated by mentors or practice teachers and were outside of the formal programme outcomes. This finding was not consistent with the literature reviewed earlier in the thesis.

Learning from role models was also evident in the data from all respondents. However, in contrast to the published literature, students were able to identify their learning from negative as well as positive role models, and they used this knowledge to develop their own professional ideals. This is consistent with Bandura's (1977) social learning theory, which emphasises the importance of learning from the observation of the behaviours and attitudes of others.

Experiential learning was evident in all interviews. However, the findings of this study do not support the notion that experiential learning requires deliberate action and conscious reflection. Indeed, there was little evidence of conscious reflection by respondents and few examples of facilitation of this reflection on experience by mentors or practice

teachers. It was noteworthy that only two respondents directly referred to the term reflection within their interviews, despite this being an explicit learning and teaching strategy within all of their programmes. Although it was evident that learning occurred following many of the experiences described, in the vast majority of instances this occurred without any active facilitation by mentors, practice supervisors or lecturers.

Mezirow developed the term transformative learning to refer to changes of meaning and perspective and has published widely in relation to his theory (1981;1991; 2000). However, Mezirow's theory of transformative learning has been criticised, because of its focus on conscious reflection as the process of learning (King, 2005; O'Sullivan, 2003). Transformative learning was articulated by all the respondents in this study but, as highlighted above, in the majority of cases this did not appear to be as a result of conscious reflection. Nohl (2008) contends that transformative learning can also occur following spontaneous action and he suggests that this presents a major challenge for educationalists, in that it is impossible to both initiate and accompany this spontaneous learning. This has resonance with many of the examples of transformative learning, described by respondents in this study, which resulted from unplanned learning opportunities involving patients and clients. This supports the critique of the narrow perspective of transformative learning, as relying on critical reflection, and is consistent with the notion of pedagogical space advocated by Barnett (2007), who argues that the main pedagogical task in higher education is to release students to engage with experiences authentically. The theoretical framework presented later in this chapter will incorporate the notion of pedagogical space to promote learning from patients and clients in practice settings. The researcher will also consider the implications of this for the roles of lecturers, mentors and practice teachers.

It is evident that the contemporary theories of andragogy, experiential, social learning, reflective and transformative learning are relevant to the context of this thesis. The new knowledge obtained in this research - that learning also occurred following unplanned, informal learning opportunities involving interactions with patients and clients - was not sufficiently explained by these theories. This led the researcher to further explore complexity theory in relation to health and social care organisations and to educational theories and philosophies, and then to apply this to the research data.

4. Complexity Theory as an Alternative Perspective for Professional Education

Chapter one provided an overview of the development of complexity theory and critically evaluated its relevance to the contexts of health and social care and to education. The researcher concluded that complexity theory is applicable to both higher education and to the health and social care organisations in which students complete the practice elements of their programmes. It was apparent that these are consistent with the concept of complex adaptive systems and that effective practice in health and social care and in their corresponding professional education programmes, requires new ways of working and learning.

As discussed earlier in the thesis, complexity theory challenges simple cause-and-effect models, linear predictability, and reductionist approaches. Rather, it focuses on large, open, dynamic systems and environments as a whole and on the connections and relationships between constituent elements, rather than the reductionist approach of traditional scientific theories (Santanus, 2006). This is directly relevant to complex

organisations which contain a large number of networks and interacting agents, which are typical attributes of health and social care environments. This is appropriate to the current policy drivers in terms of the changes to service delivery and to the need to prepare professionals to work effectively in ever changing health and social care organisations. The holistic approach offered by complexity theory, with its recognition of relationships and interconnected networks, is also in keeping with the policy changes in respect of professional and patients'/clients' roles in health and social care.

The social sciences have traditionally been underpinned by the paradigm of order and adopted a scientific approach which valued cause and effect. This led to the growth of large scale hierarchical organisations and increased specialisation and differentiation of services. Within this scientific approach, health was seen as a biomedical process; the doctor was viewed as the authority and the patient as a passive recipient of care (Geyer, 2008). However, as discussed previously, this approach has been challenged because despite the increase in technical knowledge, disease continues and the increased medicalisation of health has led to its own problems (Illich, 1996, 1997). In response to growing dissatisfaction with this traditional scientific approach, complexity theory has become increasingly popular in health and social care in recent years, (Bogg and Geyer, 2007; Cooper and Geyer, 2007; Kernick, 2004; Plsek, 2000; Plsek and Greenhalgh, 2001; Plsek and Wilson, 2001; Sweeney, 2002; Sweeney, 2006; Sweeney and Cassidy, 2006; Sweeney and Griffiths, 2002; Tennison, 2006).

Chapter one also reviewed a number of recent publications which focus on complexity theory in relation to educational theory and philosophy (Doll, 2003; 2008; Mason, 2008a; 2008b; 2008c; Morrison, 2008; Semetsky, 2008; Sumara, Luce-Kapler and Iftody, 2008) and to educational research (Davis, 2008; Radford, 2008; Santanus, 2006). These

papers suggest that complexity theory is attractive to education because of its critique of positivism, its affinity to Dewey and Habermas, and its focus on openness, diversity, creativity, agents and relationships. Although complexity theory has been applied to medical education (Fraser and Greenahlgh, 2001; Griffiths, 2002; Sweeney, 2006) and to inter-professional education (Cooper, Braye and Geyer, 2004), no publications were identified which considered complexity theory specifically in relation to nursing, midwifery or social work education. This thesis will, therefore, contribute new knowledge by applying the concepts extrapolated from complexity theory to the data from this enquiry and synthesizing these, with contemporary learning theories, into a theoretical framework to explain learning from patients and clients in practice settings.

Following extensive reading around complexity theory in relation to health and social care and to education, discussion with experts and attendance at complexity seminars, the researcher concluded that complexity theory is relevant to both health and social care and to professional education. The emphasis on networks, connectedness, relationships, communication, feedback and human agents is applicable to the data obtained in this study. It was evident that students learned from a range of individuals in practice settings, including patients, clients, professionals and other members of staff. However, the complexity of these interactions did not appear to be formally recognised and there were few examples of mentors or practice teachers facilitating learning from these networks.

Complexity theory is holistic, it incorporates order and disorder and values competence and alternative forms of knowledge, which is relevant to the requirements of professional programmes discussed earlier in the thesis. The data provide numerous examples in which students learned from these alternative forms of knowledge, for example, patient

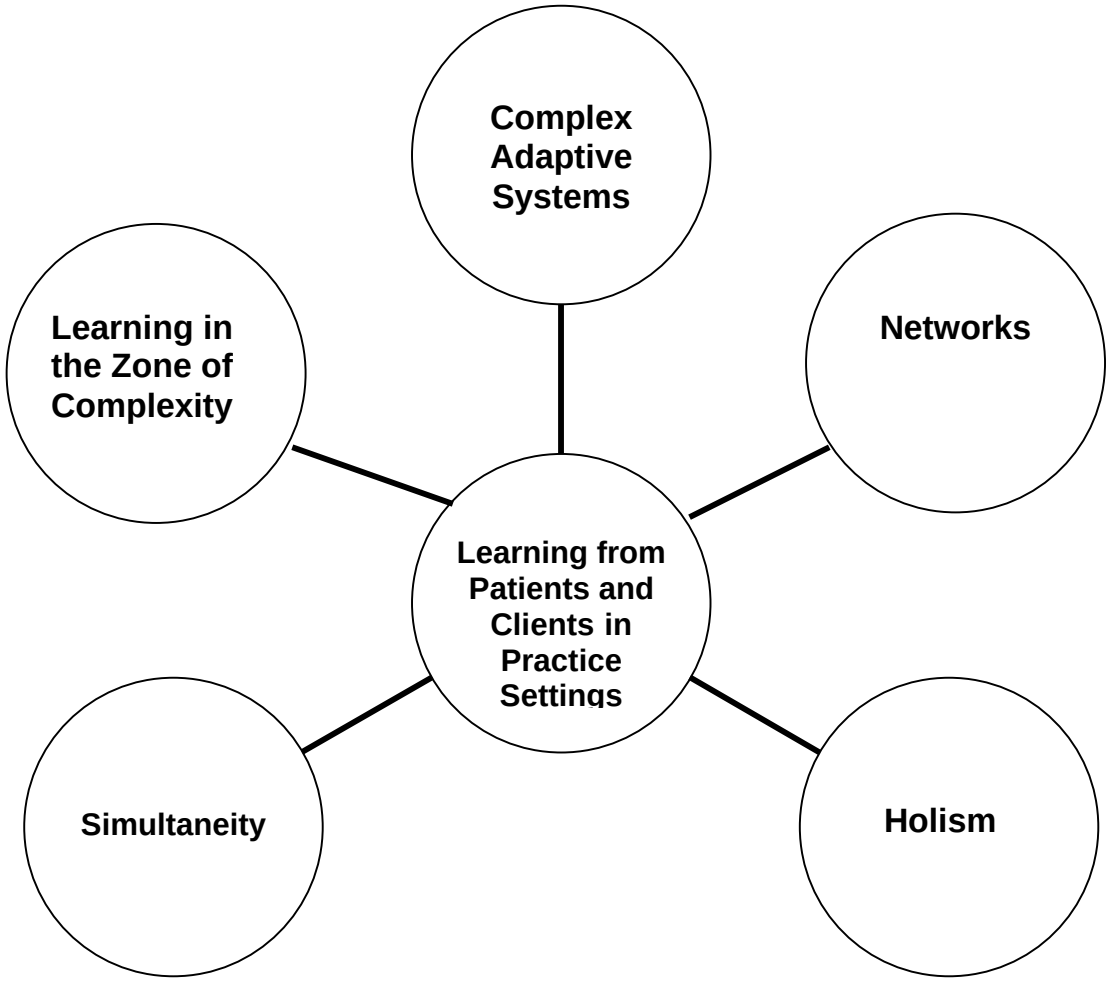
stories. It was noteworthy that much of this learning related to personal ideals and professional relationships, which complement the profession specific knowledge and competencies which are emphasised in professional curricula.

The discussion chapters demonstrated that respondents' ways of learning and the nature of that learning were inextricably linked. Complexity theory acknowledges this simultaneity and provides a framework to integrate the knower and knowing, recognising the importance of both ontological and epistemological perspectives. This was evident in the mapping exercise demonstrated in Tables 12 and 13 and in the discussion chapters, which illustrated the difficulty in separating the 'Ways of Learning' and the 'Nature of Learning' within students' responses.

One of the major constructs of complexity theory in relation to this thesis is the notion of learning in the zone of complexity, which is evident in the data. There were numerous examples of learning from critical incidents in which anxiety and uncertainty stimulated learning. However, there were also examples of situations in which the level of anxiety inhibited learning and these may be related to the zone of chaos, rather than complexity. This will be further explored below in relation to harnessing the complexity of learning in practice settings and the role of the mentor and practice teacher in supporting and promoting learning from patients and clients.

The major constructs of complexity theory discussed above are summarised in Diagram 10 below:

Diagram 10: Application of Complexity Theory Concepts to Research Data



5. Theoretical Framework to Explain Learning from Patients and Clients in Practice Settings

The previous sections applied the contemporary theories of andragogy, experiential, social learning, reflective and transformative learning, and the evolving theory of complexity, to the data. The major concepts extrapolated from these theories will be used to develop a theoretical framework, to explain the phenomenon of learning from patients and clients in practice settings, and to complement current professional curricula. The researcher acknowledges the need for competence, to ensure public safety, but proposes that alternative forms of knowledge should also be valued.

The increased emphasis on the practice elements of professional programmes, in conjunction with the modernisation agenda for health and social care, has increased the diversity of placement experiences for students. It is evident that complexity theory is relevant to the current policy drivers for health and social care, because it recognises the value, and indeed the necessity, of order and control for some aspects of care, whilst acknowledging and valuing the presence of uncertainty, rather than trying to exert control over all aspects of care.

Experiential learning was evident in the transcripts from all respondents; the data demonstrate that students were aware of the complexity of the practice environment and of the competing demands on their mentors and practice teachers. They also demonstrate the value that students attach to their relationships with mentors and practice teachers and the support that they provide. The data provided numerous examples of learning from other professionals and the concept of role modeling was a major influence on this learning. As discussed earlier in the thesis, social learning theory and role modeling are well documented in relation to professional education. Students' responses, in relation to professional relationships, were consistent with

the government agenda to empower patients and clients. However, they did report experiences which demonstrated systems of care or professional attitudes which were not empowering and in many cases they advocated for patients and clients to address these. The data also indicate that students valued equal relationships between themselves and their mentors/practice teachers.

The research findings also provide numerous examples of learning from the agents in practice settings, including patients, clients, professionals and other staff. Many of the experiences of transformative learning, particularly those involving direct interactions with patients and clients, were not actively facilitated by experienced professionals. However, as discussed in chapter seven, these findings are not consistent with the literature relating to learning in practice settings, which advocates active facilitation of, and reflection on, learning opportunities. It was evident that much of this learning occurred in the zone of complexity and incorporated alternative forms of knowledge. The researcher concludes that this learning complements the traditional professional knowledge and competence within professional curricula.

This thesis supports the simultaneity of objective knowledge and subjective knowing, (Davis, 2008), which is consistent with Barnett's (2007) focus on the ontological, as well as the epistemological basis of education. Respondents clearly articulated their own engagement with patients and clients and with their programmes, in addition to the knowledge which emerged from their experiences. Although Barnett's philosophy of higher education is compelling, it is important to consider that the focus of this research is professional education. It is, therefore, necessary to ensure that professional requirements are met, to ensure that practitioners are safe and effective at the point of registration. However, the researcher contends that curricula should also incorporate the pedagogical space required to facilitate the transformative learning reported by respondents in this study.

Discomfort is said to be an inevitable part of higher education and the data indicate that this is highly relevant to the respondents in this study. Barnett (2007) relates this specifically to medical students who are being prepared for a professional role which is, in his terms “literally incomprehensible” (p.37). He argues that anxiety is an integral part of being a student and that he or she must live purposefully with this anxiety. The data provide numerous descriptions of critical incidents from which students learned from difficult situations. However, there were several examples where students felt that they had not learned because the situation was too stressful and disordered.

Table 14 below summarises the above discussion and presents this as a new theoretical framework to explain the phenomenon of learning from patients and clients in practice settings. The researcher proposes that this:

- incorporates experiential, reflective, transformative, andragogical, social learning and complexity theories;
- provides an over-arching framework to overcome the conflict between professional regulatory requirements for competence and the personal development of individuals;
- provides a framework which values traditional and alternative forms of knowledge;
- recognises and values opportunistic, informal learning;
- recognises and promotes learning within the complexity of practice organisations;
- recognises the simultaneity between the ontological and epistemological aspects of learning;
- provides a framework for lecturers, mentors and practice teachers to provide support for students, whilst creating pedagogical space for learning.

Table 14: Theoretical Framework to Explain Learning from Patients and Clients in Practice Settings

Theme	Category	Theoretical Construct
Ways of learning	Motivation	• Andragogy • Alternative forms of knowledge • Transformational learning • Pedagogical space • Simultaneity

Ways of learning	Patient stories/critical incidents	• Experiential learning
		• Reflection
		• Learning in the zone of complexity:
		  o Support for students to avoid zone of chaos
		  o Transformational learning
		• Simultaneity

Ways of learning	Facilitation of learning	• Social learning theory • Role models • Experiential learning • Agents - patient, client and professional involvement in learning • Relationships between students and mentors/practice teachers • Simultaneity

Table 14: Theoretical Framework to Explain Learning from Patients and Clients in Practice Settings.

Theme	Category	Theoretical Construct
Nature of learning	Professional ideals	• Social learning theory • Role models • Andragogy • Pedagogical space • Transformational learning • Agents - patient, client and professional involvement in learning • Simultaneity
Nature of learning	Professional relationships	• Social learning theory • Role models • Andragogy • Pedagogical space • Transformational learning • Alternative forms of knowledge • Agents - patient, client and professional involvement in learning • Simultaneity
Nature of learning	Understanding patients'/clients' perspectives	• Andragogy • Transformational learning • Pedagogical space • Alternative forms of knowledge • Agents – patient and client involvement in learning • Simultaneity

6. Implications for Higher Education Institutions

The researcher will now consider the implications of this framework for lecturers, mentors and practice teachers and will propose strategies to harness rather than control the complexity inherent in this learning.

This thesis proposes that the Higher Education Institution has a vital role in promoting learning from patients and clients in practice settings. Lecturers, mentors, practice teachers and students should be aware of the complexity inherent in practice settings and acknowledge that students learn from alternative forms of knowledge. This diverse range of learning should complement the current curricula to develop the capability of professionals to respond to the changes in service delivery.

The difficulties facing educationalists, in attempting to provide the optimum environment to promote transformative learning, are clearly articulated by Doll (2008) in relation to the nature of the curriculum: “Order emerges from interactions having just the ‘right amount’ of tension or difference or imbalance among the elements interacting. Such a ‘right amount’ cannot be specified; it can only be felt or intuited” (p.202). This focus on distributed control is consistent with the andragogical, student centred learning approaches, considered earlier in this thesis, which are advocated to promote personal and development. However, as discussed previously, this may result in conflict within professional programmes which are constrained by regulatory requirements for outcomes and competence. The researcher concludes that both aspects of learning should be recognised and valued within professional education. It is anticipated that this thesis will add to the debate, by proposing strategies to

integrate learning from alternative forms of knowledge into curricula, to complement contemporary professional knowledge and competence.

Wagenaar (2008), writing in relation to urban planning, proposes nine strategies to deal with complexity and he argues that harnessing complexity is more effective than trying to eliminate it. These strategies include: reduce complexity; act with an awareness of complexity; organise for flexibility; connect the past and the present; try out different ideas and strategies; communication; connect different system levels in collective problem-solving; stimulate collaboration; and draw up scenarios.

It is evident, from the policies and literature reviewed in the first three chapters of this thesis, that professional education has traditionally attempted to control and reduce complexity, for example by increasing the focus on outcomes and competencies. Whilst the researcher acknowledges that this is appropriate for some aspects of professional programmes, to ensure public protection, it is less applicable to learning in the context of this thesis. Rather, lecturers, mentors and practice teachers should be aware of the complexities inherent in practice settings and provide both the flexibility and support for students to learn from patients and clients. This would facilitate transformative learning experiences, in the zone of complexity discussed above, whilst avoiding the zone of chaos which the data and literature indicate inhibits learning. Experiential learning and andragogy were directly relevant to the data in this study; respondents clearly articulated the influences of both previous and current life experience, outside of the programme, on their learning. Students, therefore, need to be given the pedagogical space to learn in a range of ways, and to try out new ideas and strategies.

The data clearly demonstrate the importance of communication. It is important to identify and value all agents in the practice area – patients, clients, carers, professionals from a range of disciplines, lecturers and other staff - and to be aware of the influence of role models. One of the strategies to harness complexity entails the involvement of different system levels in collective problem-solving. Collaborative partnerships between higher education institutions and the wide range of health and social care organisations are essential to ensure effective learning opportunities for students. In complexity terms, the concepts of co-evolution and co-emergence, where organisations develop together, would be more effective that the current position which often involves the higher education institution responding and reacting to changes in health and social care provision.

Problem-based learning, as discussed in chapter one, is widely used in professional education programmes to integrate theory and practice. Currently, this is a learning and teaching strategy which is mainly used in academic settings, but the researcher suggests that this would be a valuable strategy to promote learning from patients and clients in practice settings. It would use real life scenarios, rather than hypothetical ones, and would provide the opportunity for students to explore a range of issues and to discuss these with their mentors and practice supervisors. This would also help to recognise and value alternative forms of knowledge within professional education programmes.

Table 15 below summarises the application of these strategies to the phenomenon of learning from patients and clients in the context of this thesis.

Table 15: Strategies to Harness the Complexity of Learning from Patients/Clients in Practice Settings

Strategy	**Application to Thesis**
Reducing complexity	Option often preferred by professional bodies – emphasis on competence and outcomes Need to avoid chaos – inhibits learning
Act with an awareness of complexity	Recognise the complexity of practice placements Social learning theory and role models Support for students – work with rather try to control complexity Preparation of lecturers, mentors, practice teachers and students
Organise for flexibility	Pedagogical space Transformational learning
Connect the past and the present *and the future (added by the researcher)*	Andragogy Reflective learning Transformational learning Recognition of learning outside programme
Try out different ideas and strategies	Experiential learning
Communication/mutual learning	Patient, client, student and professional involvement in learning Awareness of networks and interactions Social learning theory and role models Articulation of expertise
Connect different system levels in collective problem-solving	Partnerships between HEIs and practice organisations
Stimulate collaboration	Partnerships between HEIs and practice organisations
Draw up scenarios	Problem-based learning in practice settings

The limitations of the study will now be addressed and the chapter will conclude with recommendations for policy, practice and further research.

7. Limitations of the Study

- As previously discussed, the researcher was interested in the experiences of all pre-qualifying students within the Faculty, to improve her own knowledge base and to conform to the current context of health and social care. It is acknowledged that this led to potential bias in terms of the researcher's own expertise in nursing. To overcome this limitation the researcher kept a reflective diary throughout the development of the thesis and addressed this issue in regular supervision sessions.

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- The researcher adopted a rigorous recruitment and selection strategy to ensure that appropriate respondents were interviewed. The sample included students from nursing, midwifery and social work pre-qualifying programmes and the intention was to elicit rich descriptions of individual experience rather than to generalise the findings or to make comparisons between groups. It is acknowledged that this may have led to bias in the nature of the students who participated, and no claims are made that these were a representative sample of the populations. Similar research with a non-volunteer group would provide interesting findings to supplement those of this enquiry. In common with many qualitative studies, the sample size for this enquiry was small, with only twelve participants. Although this is an appropriate sample for phenomenological research (Denzin and Lincoln, 1994), it is acknowledged that this means that the

conclusions cannot be generalised to other contexts. Despite the rigorous sampling strategy, the researcher acknowledges that due to less volunteers than anticipated, the final sample may be considered to be a convenience, rather than a purposive one.

- Conversational, unstructured interviews were used to ensure that experiences were described from the respondents' perspectives with the researcher probing issues but not influencing the direction of the interview. This is relevant to the descriptive phenomenological approach but it is important to note that the experiences were selected by the students and may not reflect the true extent of their learning. The researcher did not access students from her own Education Centre, but she is aware that her role as Head of Education Centre within the Faculty may have influenced students' responses. However, the transcripts demonstrate that students did appear to respond honestly and openly to the interview questions.

- From a methodological perspective, this study adopted a descriptive phenomenological approach and the method of data analysis, described in detail by Giorgi (1985, 1989a, 1995), was applied rigorously by the researcher, as used previously in a phenomenological workshop (Giorgi, 2000c) and in a previous research study (Gidman, 2001a, 2001b). Confirmability of this research is demonstrated by the rigorous application of the descriptive phenomenological method, whose purpose is to describe, rather than to interpret, experience. Whilst it is acknowledged that the 'bracketing' of prior knowledge is often regarded as a limitation of this approach (Koch, 1999) the researcher used her previous experience, reflective diary and supervision sessions to ensure that this

was achieved. The decision to use descriptive phenomenology was outlined in chapter four, to enable external scrutiny of the development of this thesis. It is impossible to know whether using a hermeneutic approach would have elicited the same conclusions, but the researcher was satisfied with both the appropriateness and adequacy of the data obtained (Morse, 1994).

- A further limitation of this study is its focus on the specific aspect of learning from patients and clients. It is acknowledged that the framework proposed in this chapter needs to be incorporated into a more encompassing one to ensure connectivity, within a holistic approach to professional education.

8. Recommendations for Policy, Practice and Research

8.1 Recommendations for Policy

- It is recommended that professional requirements for pre-qualifying nursing, midwifery and social work programmes are reviewed. They need to be more flexible, in order to recognise and value the alternative forms of knowledge and learning highlighted in this study. The researcher suggests that this knowledge would complement, rather than compromise, professional standards and outcomes. This could include the development of a holistic framework for professional education which integrates profession specific knowledge, competence and the alternative forms of knowledge gained from patients and clients.

- Preparation programmes for lecturers, mentors and practice teachers currently focus largely on the assessment of competence, which are specific to each professional regulatory body. The findings of this study indicate that these programmes should recognise the value of learning from patients and clients, and demonstrate a holistic approach to the acquisition of knowledge in practice settings.

- Closer collaboration between universities and practice organisations, at both local and strategic levels is recommended. This would help to develop co-emergence and co-evolution of both organisations, rather than the current situation whereby universities react to changes in practice. This would enable more effective facilitation of learning for pre-qualifying nursing, midwifery and social work students during the practice elements of their programmes.

8.2 Recommendations for Practice

- The data from this study demonstrate the value of learning from patients and clients in practice settings. The researcher intends to disseminate the research findings, locally and nationally, to lecturers, mentors, practice teachers and students and hopes that this will positively influence practice.

- This thesis highlights the need for lecturers, practice teachers, mentors and students to recognise and embrace the complexity of practice settings as learning environments. Learning and teaching strategies in practice should harness, rather than attempt to control this complexity.

- Lecturers, practice teachers, mentors and students should value alternative forms of knowledge, for example patient stories, to complement professional outcomes and competency requirements.

- The roles of agents within practice settings, in relation to student learning, should be acknowledged and strategies implemented to enhance networking and communication. These agents include a range of health and social care professionals, other members of staff, patients, clients, carers and students. The impact of the socialisation of students into the practice area and the effect of role models on their learning should be acknowledged.

- Mentors, practice teachers and lecturers should provide optimum levels of support for students. They should facilitate the pedagogical space required for learning in the zone of complexity, whilst avoiding the zone of chaos, which may inhibit their learning.

8.2 **Recommendations for Further Research**

- The researcher applied Giorgi's descriptive phenomenological approach to the context of learning from patients and clients in practice settings for the first time. She concludes that it is an appropriate approach for this context and hopes that this thesis will contribute to further development of the methodology in professional education.

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- This thesis focuses exclusively on students' perceptions of their learning from patients and clients. It would be interesting to combine these perceptions with other data, for example an ethnographic approach involving observation in practice, interviews with patients and clients and interviews with mentors and practice teachers.

- The data suggest that there may be a potential link between student and patient empowerment, as advocated in both contemporary health and social care policy, and the ethos of higher education. This would merit further investigation, again using an ethnographic approach.

- The researcher did not conduct follow-up interviews with respondents, because it was not considered relevant to the aim of this enquiry. In the light of the extensive literature relating to the socialisation of professionals, it would now be interesting to explore whether the respondents' professional ideals changed following their qualification and integration into the work setting.

- The researcher articulated her decision not to adopt a grounded theory approach, but as this thesis evolved, contemporary and complexity theories became integral to its development. Analysis of the data from this exploratory study was used to generate a theoretical framework to explain learning from patients and clients in practice settings. The researcher intends to disseminate and discuss this framework with academic and practice colleagues and hopes to conduct further research to evaluate its wider relevance.

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Appendix 1

Summary of Research Studies Relating to Patient and Client Involvement in Professional Education

Appendix 1: Summary of Research Studies Relating to Patient and Client Involvement in Professional Education

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Ager, W., Dow, J. and Gee, M. (2005)	To explore perceptions of level of involvement in social work education programmes	120 practice teachers, 46 students and 28 service users and carers	Questionnaires to students Focus groups with service users and carers	Conclude that service users and carers in this study were 'involved', 'informed' and 'consulted' which are all at the lower rungs of the ladder and they aim to progress towards 'influence on action'
Bailey, D. (2005)	To involve service users in the assessment of professional competence	27 self-selected service users and 9 course participants	Action research Focus groups - grounded theory approach to analyse data	Service users provided detailed, constructive and meaningful feedback which clearly related to issues of importance from a user perspective.
Barnes, D., Carpenter, J. and Bailey, D (2000)	To evaluate the involvement of service users in the development, delivery and evaluation of an interprofessional, postgraduate mental health programme	9 service users, 24 students and 29 user groups.	Case study – documentary analysis, peer and group interviews	Conclude that data provided evidence that service users' knowledge was identified and used and of added value in terms of interprofessional working for partnership
Barnes, D., Carpenter, J. and Dickinson, C. (2006) Carpenter, J., Barnes, D. and Dickinson, C (2006).	Five year evaluation of the involvement of service users in the development, delivery and evaluation of an interprofessional, postgraduate mental health programme	120 service users 44 students	Participant observation Questionnaires Group interviews with students and their managers	Service users rated the quality of care provided by these students - outcomes for service users were positive, but this was also reflected in the comparative group so no conclusions can be drawn in respect of the programme. Student attitudes and behaviour were positively influenced in relation to partnership working and service user involvement in care.

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Costello, J. and Horne, M. (2001)	To evaluate a project to involve patients in teaching sessions	3 patients and 23 adult pre-registration nursing students	Questionnaires to evaluate sessions.	Students - sessions provided valuable insights into patient experience. Patients – benefit from their involvement, opportunity to engage in dialogue with students and to contribute to teaching and found experience cathartic
Edwards, C (2003)	To explore practice teachers' views about service user involvement in social work education	8 practice teachers	Semi- structured interviews - grounded theory approach to data analysis	The service user was perceived to contribute to feedback on student performance but to have no responsibility for the assessment process
Elliott, T., Frazer, T., Farrard, D., Hickinbotham, J., Horton, V., Mann, J., Soper, S., Turner, J., Turner,M. and Whiteford A. (2005)	Evaluation of project – structured conversations between social work students, service users and carers	56 social work students and 33 service users and carers.	Interviews with 23 service users Questionnaires to students	They report that this process reverses the usual power imbalance, with users and carers acting as informal assessors and making judgements about students' interpersonal skills, values and assumptions
Felton, A. and Stickley, T. (2004)	To explore lecturers' views in relation to service user involvement in pre-registration nurse education	5 lecturers	Interviews Thematic analysis of data	Several barriers to effective involvement were identified relating to the concepts of role and power relationships

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Forrest, S., Brown, N. Risk, I. and Masters, H. (1998) Forrest, S., Masters, H. and Brown, N. (2000)	Obtain service users views to influence development of mental health programme	34 mental health service users	Interviews with grounded theory approach to data analysis	Themes identified in relation to conflict between professional and service user views. Need to agree level of involvement and to develop strategy for implementation
Gidman, J. (2001)	Explore student nurses' perceptions of learning in practice	9 Pre-registration nursing students in UK	Descriptive phenomenology – in depth interviews	Mentor and clinical learning environment have major effect on quality of learning experience. Link tutor had minimal effect Students reported valuable but 'ad hoc' learning from patients
Hanson, B. and Mitchell, D.P. (2001)	Evaluate a five day course involving service users	9 mental health students	Questionnaire and nominal group technique to evaluate programme	Positive responses but no comments directly related to learning from service users. Post-course evaluation after six months indicated that it had facilitated participants to subsequently become involved in a range of user issues
Happell, B. and Roper, C. (2002) Happell, B., Pinikahana, J. and Roper, C. (2003)	Case study approach to implement and evaluate a 'consumer academic' role	25 mental health nursing students in Australia	Pre- and post- course attitudinal questionnaires	The data demonstrate positive attitudes in respondents at both phases of the survey towards consumer participation although this was increased post course

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Jackson, S. and Morris, K. (1994)	Review teaching of partnership in Family and childcare	Social work degree students, lecturers and practice teachers in UK	Questionnaires Tape recorded discussion	Lack of definition of partnership Integrated approach to partnership More effective when partnership linked to practice learning Need greater understanding of how oppression creates barriers to partnership
Julia, M. and Kondrat, M.E. (2000)	Determine the extent to which social work research methodology encourages active involvement of those shoes lives are being studied	Social work programmes in US	Content analysis of research methods courses in social work programmes	Minimal attention given to participatory research or to empowerment and collaboration in research process.
Khoo, R., McVicar,A. and Brandon, D. (2004)	Students' perceptions of service user involvement	26 mental health practitioners who had previously completed a post-graduate programme	Retrospective study Telephone interviews and questionnaires	The majority (87%) reported that they had benefited personally and professionally from the involvement of service users in the programme and many had implemented change in practice as a result of this.
Lathlean, J., Burgess, A., Coldham, T., Gibson, C., Herbert, L., Levett-Jones, T., Simons, L. and Tee, S. (2006)	Evaluation of a project to introduce a 'service user academic post' into mental health programmes in a UK university	Purposive sampling - 35 students, 6 service user academics 10 lecturers	Observational case study approach	The researchers conclude that the service user academic was a powerful role model for students and was an effective way to integrate service users' perspectives into the curriculum. However, they report that organisational factors inhibited the introduction of socially inclusive practices.

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Simons, L., Tee, S., Lathlean, J., Burgess, A., Herbert, L. and Gibson, C. (2007)	As above	As above	As above	As above
Masters, H., Forrest, S., Harley, A., Hunter, M., Brown, N. and Risk, I. (2002)	To evaluate service user involvement project	33 stakeholders - students, lecturers, service users and carers,	Questionnaires – quantitative and qualitative data	Project was evaluated positively by all stakeholders. The emotional aspect of involvement and the time and enthusiasm required were highlighted as central to the process.
McAndrew, S. and Samociuk , G.A. (2003)	Evaluation of reflective sessions timetabled within placements	7students, 5 patients, 2 lecturers and 1 observer	Case study approach taped and transcribed reflective sessions Pre and post test attitude questionnaires - students and service users	Initially service users felt in dominant position offering neophyte nurses their expertise Students collaborative in their approach and concerned about confidentiality, need for safety within the group and not being held responsible for issues within the NHS
Molyneux,J. and Irvine,J. (2004)	Survey of Approved Social Worker Programmes	19 programmes	Documentary analysis Focus groups with service users and carers	Users and carers felt that they could be more involved in programme delivery, assessment and evaluation and the data indicated that involvement was largely at the lower end of the continuum.
Morgan, S. and Sanggaran, R. (1997)	Evaluation of a project to use feedback from mental health service users to facilitate student learning	43 students and 74 service users	Evaluation - questionnaires	Both groups endorsed service user participation in student learning and the researchers recommend that this approach is further developed in nurse education curricula.

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Price, J. (2004)	Project to involve parents of children with complex needs in teaching sessions	35 students and 1 observer	Action research	Responses indicated that the experience acted as a powerful stimulant to students, it gave a realistic view, encouraged theory and practice integration and presented issues in a memorable way
Scheyett, A. and Kim, M. (2004) Scheyett, A. and Diehl, M.J. (2004)	Explore the effects on attitude of facilitated dialogue between consumers and social work students	10 Social work students and service users in US	Pre- and post- test attitude scales following one day intervention - students Interviews – students and service users	Changes in attitudes significantly positive in relation to stigma and relationships, empathy, understanding, awareness of consumer strengths and skills. Recommend that policies need to be developed to enable service user involvement in assessment and evaluation and to overcome barriers in relation to roles and responsibilities, confidentiality consumer preparation.
Shor, R. and Sykes, I.J. (2002)	Evaluate the effects on attitude of structured dialogue sessions with social work students and mental health service users	Social work students in Israel	Pre- and post-test attitude tests of social work students following structured dialogue	No significantly relevant changes in attitude between pre-and post test data Qualitative data suggests that sessions promoted learning from people with mental illness in an open non-threatening manner
Speers, J. (2007)	To explore stakeholders' views of involving service users in the assessment of competency	5 service users, 7 students, 4 ex-students, 6 mentors and 2 lecturers	Semi-structured individual interviews with service users Focus groups with students, ex students, mentors and lecturers	The findings indicate differences in responses between the four groups although all were largely positive about the concept of service user involvement. Nurse participants expressed reservations about the implementation of the proposal in practice although were in favour in principle.

Authors	Aims of study	Sample	Design and methods	Findings and conclusions
Taylor, I., Sharland, E., Sebba, J., Leriche, P., Keep, E. and Orr, D. (2006)	Review current practice in respect of the learning, teaching and assessment of partnership	Social work programmes in the UK Education providers	Survey of programme (33) and module (9) handbooks 14 In-depth telephone interviews and 4 focus groups –thematic analysis Analysis of examples of good practice	Two main approaches to partnership evident in programmes: o embedded approach - partnership education is integrated into the curricula o discrete approach - discrete modules focus on partnership. Integration of clients in programme structures, processes and content is not well developed.
Wikler, L. (1979)	Investigate the way in which consumer interviewing differs from lecturers and students	Parents of 'mentally retarded children', lecturers and students	Descriptive study of process and experiences of involving parents in interviews.	Importance of consumer involvement in social work education No clear consensus between lecturers and parents as to interviewing skills but both agreed that most important feature is that the interviewer should 'really listen'.

Appendix 2

Descriptive Phenomenology Workshop: Professor Amedeo Giorgi

Reflection on Phenomenology Advanced Workshop (Professor Amadeo Giorgi)

Jan Gidman 16/4/99

This one week workshop was led by Professor Amadeo Giorgi, a renowned psychologist and expert in phenomenological research. He was presenting his approach which promotes the use of Husserl's descriptive phenomenology rather than Heidegger's interpretive approach. Giorgi is the first to have applied it in this way – he said he did so to argue the case for phenomenological research in the scientific community. This reflects his empirical background and he claims that the approach has scientific rigour but stays true to phenomenology. He strongly argued for the descriptive approach, claiming that it is more rigorous and can be defended in the scientific community, whereas he feels that interpretative phenomenology is harder to justify.

I was attending the course as part of a Welsh National Board research fellowship. My interest was in qualitative, rather than quantitative research, but not specifically phenomenology, although it did seem relevant to my topic – I wanted to explore students', mentors' and teachers' perceptions of clinical teaching. I was concerned that the level of the course would be too hard. Although I had completed research modules at degree and masters levels I was not well read in phenomenology. This feeling was reinforced on the first morning – the rest of the group were at PhD level or beyond and seemed to know a lot more than I did! On reflection, it was my lack of preparation for the course, rather than my ability, that made me feel like this. My feelings of insecurity and confusion were allayed during the first session which involved a discussion of the relative merits of qualitative and quantitative research approaches. I was familiar with these arguments and was able to contribute to the discussion which confirmed my intention to use a qualitative approach within my own study. However, the anxiety returned very quickly! The following session focused on the philosophical underpinnings of phenomenology which I had not encountered before and I found the language and concepts extremely difficult to grasp. Other members of the group also found this session difficult but I felt very guilty that I had not prepared sufficiently for the course due to workload.

As the week continued it became clear that even experienced researchers were finding the course very challenging and I became less self conscious and more able to enter into debate about descriptive phenomenology. By the end of the course we were applying the approach to a range of examples relating to learning which helped me to begin to understand the method. I found the concept of 'bracketing' the hardest to grasp and I am aware that I need to develop my skill in this if I am to use the approach rigorously within my own project.

I was fortunate to be able to practice using the approach under the guidance of Professor Giorgi and I was convinced that descriptive phenomenology was appropriate for my research project. On the final day we had a working lunch to discuss our own projects and Professor Giorgi strongly advised me to use his method. He also reassured me that 'bracketing' is a skill that requires practice and he offered constructive advice in relation to my research proposal.

What did I learn?

- I have begun to understand the philosophical underpinnings of phenomenology
- I now have a basic understanding of both descriptive and interpretative phenomenological approaches to research.
- I have a reasonable understanding of Giorgi's method and its practical application
- That I have a lot still to learn.
- To ensure that I prepare for courses – no matter what the work pressures.
- Not to underestimate myself! By the end of the course I was able to engage in theoretical debate with experienced researchers.
- That I want to continue to PhD studies when I complete my Master of Education programme.

Appendix 3

Faculty of Health and Social Care Ethical Approval

(see hard copy in thesis)

Appendix 4

Information for Participants

An Exploration of Students' Perceptions of Learning from Patients/ Clients/Service Users During Practice Placements.

Information for Participants

Research Interviews:

My name is Jan Gidman, I am Head of Centre at the School of Nursing, Midwifery and Social Care (Chester college site) at University College Chester. I am currently undertaking a research project for my PhD studies.

I am interested in your experiences of learning from patients/clients/service users during your practice placements.

As a participant in the project, you would have several very definite rights:

- participation is entirely voluntary
- you are free to refuse any question at any time
- you are free to withdraw from the interview at any time
- the interview will be strictly confidential
- excerpts of the interview may be used as part of the final research report, but no names or identifying characteristics will be included.

I am / am not willing to be contacted to arrange an interview at a convenient time.

(Please delete as appropriate).

…… Signed

…….. Name

…….. Date

Appendix 5

Consent Form

An Exploration of Students' Perceptions of Learning from Patients/ Clients/Service Users During Practice Placements.

Consent Form

Research Interviews

My name is Jan Gidman, I am Head of Centre at the School of Nursing, Midwifery and Social Care (Chester college site) at University College Chester. I am currently undertaking a research project for my PhD studies.

I am interested in your experiences of learning from patients/clients/service users during your practice placements.

Thank you for your willingness to participate in this study. Your participation is very much appreciated. Before we start the interview, I would like to reassure you that, as a participant in the study, you have several very definite rights:

- participation is entirely voluntary
- you are free to refuse any question at any time
- you are free to withdraw from the interview at any time
- the interview will be strictly confidential
- excerpts of the interview may be used as part of the final research report, but no names or identifying characteristics will be included.

I would be grateful if you would sign this form to confirm that I have read the content to you and that you agree to participate in the interview.

…… Signed

…….. Name

…….. Date

Please send me a copy of the completed research report YES / NO (delete as appropriate).

Address for research report if requested:

……

……

Appendix 6

Transcript of Interview Eight

Interview 8

Meaning Unit 1

J: What I am interested in is your experiences of learning through the practice placement -particularly what you've learnt through the sort of patients and clients that you've had dealings with over the couple of years.

R8: Yes.

J: Anything you say is going to be confidential. So if you mention people's names or units or whatever I'll just, when I come to type it all up I just won't put it in. If you say anything that you want to retract, that you think - "oh I wish I hadn't said that, I didn't want that really recording" - just tell me at the end and I'll make a note of it and again when I transcribe it I just won't add that bit in.

R8: Yes, yes

R8 consents to interview

Meaning Unit 2

R8: So what kind of things?

J: Tell me, just what you were talking about before we started, about what you've done so far, in your practice.

R8: Well basically, for the first twelve months, we did three placements, one in general, one was mental health and one was learning disability - learning disability being the speciality that I'm going into.

J: Yes.

R8: And the general I really enjoyed. It was based at *(names Trust)* and erm, erm, I mean they did ask me at the time if I wanted to change over to general.

J: Oh right

R8: but personally I felt that from a nurse point you've got no time with the patients. And I think in the other areas like mental health and learning disability at least you've got, its identified isn't it holistically that that time is important. I think I would find that very frustrating.

R8 explains her placements to date during her learning disability nursing programme. She compares her experience in general nursing placements to that in learning disability and mental health and observes that nurse sin general wards have less time with patients, which she would find frustrating.

R8 compares her experience on general wards to that in learning disability and mental health areas and reflects that she would find the lack of time to spend with patients, in general nursing, frustrating.

Meaning Unit 3

R8: I was very impressed and very appreciative that the nurses did actually take a lot of time out to show you things which I think, listening to other students, isn't always the case. And I think being a mature student helps.

J: Do you?

R8: Because I think you can say whoa, hang on. I mean I haven't got a problem at all doing hands on care at all. But when, because on our course we're supernumerary and in a lot of areas the feedback is that you're not classed as supernumery. Erm, but I don't mind being included in the numbers as long as there's enough people to carry you

at some point you take time out to observe something or something like that. You don't want to be feeling that you're leaving somebody else to carry your workload, that's the idea of being supernumerary.

J: Yes, definitely.

R8: So and I think as a mature student you've got that bumph, I mean some of the younger one's have but I think I'm able to say – "hang on a minute I am supernumery". And I do have to say it on many occasions. Because the old trainees they weren't supernumery in their third year.

J: You're thinking of the old elective placements?

R8: Yes. They weren't supernumery, which I am taking on this kind of placement. So, erm….

J: How do people respond when you?

R8: I think its how you present it really. Like I know it caused mayhem once, when one student said I'm only here, I haven't come to do any work, I'm only here to – she got the wrong concept of supernumery I think, yes. I wish. (Laughs) You know, I like to believe you're part of a team and I've been made to feel that in every area I think.

R8 explores her role as a student and reflects on her appreciation when qualified staff spent time with her. She reflects that, in her experience and that of fellow students, supernumerary status is not always adhered to. R8 explained that her status, as a mature student, enabled her to explain her role to mentors and to integrate into the team. She compares this with the experience of younger students whose understanding of the term 'supernumerary' sometimes caused problems on placements.

R8 displays a mature attitude towards her role as a student and her place in the team and compares this to the attitude of younger students.

Meaning Unit 4

R8: From, for my general placement I mean obviously you pick up your basic clinical skills. But I did feel that the feedback from the patients was very important. You know when you give someone an injection they actually tell you it hasn't hurt.
Laughs.

J: Would you actually ask them or would you wait for them to?

R8: Erm, I've had comments, you know because obviously you have to tell them first that you are a student and will they give their consent for you to give them treatment. And I suppose they know that you need that reassurance. I mean sometimes people aren't, they're not that, but yes I appreciate the feedback that I got from patients in that sense.

R8 reflects on her learning from positive feedback from patients in relation to clinical skills and recognises the importance of telling patients she was a student when gaining consent.

R8 values feedback from patients to help her learn and gain confidence in clinical skills and recognises the need to obtain consent.

Meaning Unit 5

R8: And the fact that as a student you can take time out and sit with people and talk to them when the other nurses, not because they can't but because they haven't got the time.

J: Is it because they haven't got the time do you think?

R8: I think so. I mean I suppose some people do get a bit blasé don't they because six days out of seven I suppose if they haven't got the time its something that goes by the wayside isn't it. And within our training I think there's more of an emphasis on the communication side of it. You know from talking to people.

R8 explains that, as a student, she has time to talk to patients, whereas this is compromised for qualified staff, on a busy ward. She explains that her programme emphasises communication.

R8 reflects on the difficulties of effective communication within a busy ward environment.

Meaning Unit 6

J: So what sort of thing did you, you sit and talk to patients, what sort of things would you talk about?

R8: Erm….how they were going to cope when they went home I felt was very anxious period for people. And, erm, erm, because a lot of elderly because I was on an orthopaedic ward we'd have a lot of elderly admissions because of fractures of hips etc and their life was going to change completely because they weren't going to go home. And erm, erm, I think one of their anxieties was they didn't seem to be that involved in their care package, erm, because, because they're bed blocking aren't they. So it's like well this nursing home has got a vacancy and there isn't a choice issue. Whereas if you're already in the community there might be visiting places mightn't you to go and have a look?

J: So not only have they got to cope with going to a nursing home but they didn't have any say in it at all?

R8: Yes that was a lot of the feedback was they wouldn't, erm, you know, I mean for all whatever good purposes they've got to be discharged

because it becomes a social issue, but erm, there'd only be so many places available from a social worker's point of view. And a lot of people, because it's all possessions and everything. Because if they haven't got family to, it's quite traumatic. That's not part of your role, but it is because the anxiety part actually affects the heart doesn't it.

J: How was that dealt with in a general ward?

R8: I don't think they've got time for it really.

J: Because that sounds, from what you say that for me would be a huge thing.

R8: Yes, yes. Especially you know if they've got no family and it's the whole, you know, so I suppose, because I felt because I'd worked in learning disability for years and we'd always used an advocacy service whereas for limb disability that's something that's been going for a long time. But there isn't that much for people in the general population, that is actually a plus side for whereas you know like if someone is admitted to here it's automatically referred to the advocacy service.

J: Right.

R8: Erm, so that they've got somebody that can stick up on their behalf in any meetings or anything or alongside them. Whereas an elderly person that's on a general ward that's confused has probably got the same needs but they haven't got that service there.

J: That's interesting isn't it?

R8: So you know, erm, sometimes you feel, I say "excuse me but you know you're not listening to what this person wants" and that's part of your role I suppose nurse. I've found that very frustrating whether it's because I've worked in learning disability before I don't know. Maybe if I had gone in just blind maybe I wouldn't have seen the deficit because I wouldn't know the services out there would I?

J: No

R8 reflects on her experience of caring for elderly patients on an orthopaedic ward. She describes the system of transferring patients to nursing homes, to prevent 'bed blocking'. She recognises that this is a traumatic experience for many patients and is surprised and frustrated that nurses do not act as their advocates. She compares this to learning disability nursing where the advocacy role is very strong.

R8 recognises the needs of elderly patients and is disappointed in the nurses' lack of advocacy which she compares to her own experience within learning disability settings.

Meaning Unit 7

J: No. But it does, I mean, from what you say it sounds like those people are as vulnerable as somebody with a learning disability.

R8: Yes very much so, yes. And one of the frustrating things because a lot of the elderly people that come in were very confused just because they'd possibly had a hip operation and then, erm, they'd be identified with a urine infection which affects their mental health. The first two or three days after the anaesthetic and because they've got a urine infection they're very confused. And you're thinking to yourself, "why isn't there some sort of system in place that erm they could", you're wondering have they fell over because they're confused because they've got urine infection in the first place. And it would be preventable if you could just do something to stop these people, to be picked up before they got into that state basically. Because after two or three days they're totally a different person, very compus mentus.

J: So it's treating the infection when it's diagnosed rather than later.

R8: Yes, you know, sort of maybe if there was more input on them community care before they became so confused and unwell. I mean, you know, I mean its only hearsay that that's why they fell but it makes you wonder how they did cope at home. And then you know all these people with urine infections, they must be you know and a high percentage of them have got a urine infection. That's what it seemed like at the time when I was on the ward and erm…

J: What is it that you, why do you think you sort of noticed that rather than …?

R8: I think because previous to me student training it was identified where I worked that urine infections interfere with people's behaviour because they got confused.

J: So this is in a learning disability setting?

R8: Yes.

J: Right.

R8: Social care - because I managed social care homes - so one of our care pathways would be if somebody became unwell in any way it would be automatic to test the urine.

J: Right.

R8: Because we had already identified that that was problematic, especially for female clients. So we would do that whereas a person living in their own home wouldn't have that input would they?

R8 explains that urine infections can cause confusion in elderly patients and that this can influence their recovery. She observed that his affected a large number of patients on one ward and reflects that the infections could have been identified at an earlier stage. She uses her previous experience, in social care settings to reflect on this experience.

R8 reflects on the care of patients in hospital with urine infections and applies knowledge from previous experience to suggest improvements to care.

Meaning Unit 8

J: So you're using a lot of what you had in previous experience?

R8: Yes I think it helps. I feel because a lot of the younger students have possibly done psychology and sociology, I don't think they'd invented them at school when I was at school (laughs) So they've got that to fall back on, its life experiences I feel that have helped me along, you know. They haven't got my model of bullshit.

J and R: Laugh

R8: When I opened up the, because I don't know whether you've seen the programme? It's got sports every Wednesday afternoon on the programme.

J: Oh Yes

R8: I nearly had a heart attack!

J and R: Laugh

R8: I though "ay up, what's this her?" I got quite a sweat on! But I did a mental health placement and I do actually, in fact I've actually got some of the mentors' comments on this because I've got my profile on me if you want to read them.

R8 compares her own knowledge, gained from experience, to that of younger students and reflects that her experience has helped her to learn more effectively during the programme.

R8 reflects on the role of experience in her learning.

Meaning Unit 9

J: Yes what did they say?

R8: Well I was reading them the other day because I actually went for an interview on Monday and…… I got the job but it's not with this Trust.

J: And they wanted you to begin?

R8: Well I actually have always worked for *(name of Trust)* and I had an interview with them on Monday and was successful. So I'm going, I needed to know that I've got some income come February when I qualify.

J: Of course it's February isn't it?

R8: Yes. So all of a sudden you realise you've got to start applying for jobs. Yes. So it's a bit iffy because they've given me a place for two years because they need to attract newly qualified nurses as well.

J: But then if you're going to give them a good press when you go back and talk to other students about it it's still been worth it.

R8: Oh definitely.

J: You know.

R8: And they sent me an application form without me asking for it. But, erm, I don't want to burn any bridges because you don't know in the future where I want to be.

R8 explains that she has recently been offered a job when she qualifies, but that it is not within the current Trust.

R8 has been successful in her job application.

Meaning Unit 10

R8: But erm, on my mental health one, I felt that my mentor was actually, I put on because my previous experience said that I would be able to cope in that setting because it was community.

J: Yes.

R8: And that was my first year and they were able to give me a case load. Whereas a new student wouldn't have been able to cope with…..

J: Certainly not with a caseload.

R8: And I got an appropriate placement. But I think that's what allocations actually struggle with is getting appropriate placements. Because I think it's very sad because the general students when they go into the learning disability setting do not get this kind of placement. They go into residential, so their view of learning disability nurse is that they're cooking and wiping bums basically. They don't see the whole part of the role and I think that's where relationships break down when you have to access primary care because they don't actually see you as a nurse. I don't think they actually see you do nursey things.

J: So it's perception of what you're doing?

R8: Yes. Yes. They see you in a group home which, you know some mental staff nurses do choose to do that role but, erm, not in an acute setting like this. I don't think they actually see it. But there isn't that many placements that's the problem. I don't say it's the college's fault, it's actually …

R8 explains that, due to her previous experience, she was given more responsibility than other students during her placements. She identifies the importance of acute learning disability placements as learning opportunities and reflects that students who do not get an acute placement (due to placement shortages) may have a distorted view of the role of learning disability nurses, which can lead to lack of respect.

R8 reflects that if students are not exposed to acute placements, they may not have an accurate perception of the role of learning disability nurses.

Meaning Unit 11

J: ……send two hundred students all to….

R8: So I think it's sad but from the mental health side I mean I felt, the feedback from patients there, because I think I worked in a very good setting, where they've got a very good relationship with the patients and the patients were very grateful. Because it's rural, isn't it *(names area),* I mean.

J: Yes.

R8: So I think their caseload isn't as intense as possibly some other areas, so they've got time to …

J: To be with the patients?

R8: Yes. And they were very grateful. It was over the Christmas period that I was actually on placement with them and, erm, the anxiety of these people because services closed down. And, erm, I learnt a lot of very good role models because the community nurse had just sort of blanked out days where she had just basically gone "sorry there's a list of people Christmas Eve", particularly people who have got no family, taking them out for lunch. She considered their mental health they needed to know that there was going to be about basically. It was very, very good role modelling.

J: Again that's your preventative side isn't it?

R8: Yes, yes very much so. People won't go into crisis over the Christmas period?

J: She had a lot of lunches did she?

R8: You know, you could hear people say well she'll be around at Christmas sort of thing. And it is a sad time to be on your own as well isn't it, well obviously.

R8 describes her experience on a rural placement over the Christmas period. She recognised the anxiety that this causes many patients and the potential impact of there being reduced services at this time. She reflects on the care provided by a positive role model, who made herself available at this time.

R8 reflects on the behaviour of a positive role model, who recognised the potential effects of Christmas on patients and responded appropriately.

Meaning Unit 12

R8: But I think I was lucky because I think the services that I had my placements in were good so you didn't actually get patients that were, erm, complaining about the service they got as well. Funnily enough on my general placement they had got a very, erm, problematic patient that when admitted, the story went that he had split up from his wife when he was admitted, so he wanted re-housing before he could be discharged. Erm, and I felt dealing with that patient's attitude very difficult. I felt this was somebody who knew the system very well, erm, PALS were involved because he was complaining on numerous occasions. It actually gave me a crack up when he said PALS at first, you know I thought it was something that your dog ate! And he had been put in a single room and we couldn't get him out of it. And they'd got somebody who was terminal. And I was like, push his bed out, you know what I mean and he was one of these that just knew which buttons to press all the time. And taken his car off the car park and

everything, we just had a real handful. He's in a brace on his hip and he's driving a car.

J: And how did they deal with him?

R8: Obviously, I mean, they tried to built up a rapport with him so they could deal with the issues before they became too problematic I suppose but we involved social workers and all the multi-disciplinary really. The police were called at one point, security were called because obviously it was unsafe he was driving out of the car park with his car. Erm, and then he took himself off on home leave that's how they got the room back. I think it gave me a different view point because obviously you've got to deal with everybody the same.

R8 explains that she has experienced good services for clients and so had encountered very few complaints. She then reflects on a difficult situation within a general ward when a patient was very problematic. He complained regularly and refused to give up a single room to accommodate a terminally ill patient. R8 describes how the PALs service, social workers, security and the police all became involved when he insisted on driving but was not safe to do so.

Although she recognises the need to treat patients in a non-judgemental way, R8 expresses her annoyance at the way a particular patient manipulated the system.

Meaning Unit 13

J: Non-judgemental?

R8: Yes, that's it ……laughs ….. because that's one thing with me because your clinical skills, I mean I know you've got to practice as a student but I always felt guilty that you might have made somebody hurt when they wouldn't, if somebody else had got more difficult, I felt because the client was learning disabled, so they wouldn't have that anxiety even though you explain that you are a student would they comprehend?

J: Whether its true consent?

R8: Yes, yes, you know I felt that was very difficult so I did appreciate the general for that because at least you knew people were being compliant, you know.

J: They knew what they were agreeing to?

R8: Yes, yes. I thought that was, but I can't really. I mean from patients, I think patient's attitudes I learnt from the fact that if you treat somebody how you want to be treated I felt was valued by a patient. Because if you treat a person with respect you get it back don't you. I don't think I've ever been at the end of any abuse.

J: Is that across all placements?

R8: Across all, all placements really. And patient's relatives, erm, building up a rapport with those. The one thing that I find funny from that is because you'll go and have your lecture on confidentiality and learning disability and the next thing they're saying is involve the carers and the relatives. Just being argumentative, because I like to be argumentative.

J: Quite right.

R8: And I thought, I said to our tutor because we'd just had in the morning the confidentiality one and then he was saying so here's an assessment someone has been referred from a day centre because they've got behavioural issues the first thing you do it contact the family. I said I wouldn't have said that was the first thing you do. And he said well, get permission, he said that's not how it works. And I said "but I don't know how it works, I want to know how it should work".

J: Quite right, that's not argumentative.

J and R8: Laugh

R8: I want to know what the gold standard is and then you can tell me how I cut corners really. And I said because that person's an adult and they

might not want, I said it might be a sexual issue they've got at the day centre, they might not want their mum and dad to know they've got a relationship. And he's saying but you need the information, I said but you need to get their respect first, I said. So you need to get their permission to approach. He said well they might not know. I said "well they should know there's a referral gone in about them, shouldn't they".

J: So he wasn't expecting it then?

R8: Well no, he was saying this is how it happens basically and that's well I don't want to know how it happens, I want to know how it should work.

J: How it could be improved. What were the other students saying?

R8: Well they know I'm gobby anyway - we want to go home, shut up. But its true isn't it.

J and R8: Laugh

J: Well you're right you should be looking at best practice shouldn't you and challenging everything that doesn't meet that?

R8: Because learning disabilities people do forget they're adults I think, you now, a lot of the time. You know we've had a client recently who was obviously being led by a parent. And somebody said well it's their child. I said but "she's an adult". It's you know when somebody has been, it's a form of abuse even though its done with the right intention, for the right reasons. You know the fact that you're actually brainwashing somebody I think is a form of abuse isn't it? Because they want to veer it round to how they want it, they wanted her to move closer to them even though she was happy where she was. It happened because it was their child. You know the fact that she was forty two, I don't think.

J: That she was a child?

R8: Yes. That's true.

J: What do you think you've learnt differently, or specifically, not just in your training but before with learning difficulties rather than general?

R8: I think that people see the disabilities. From both points of view I think people see the disability before they see the person. And I think that people with a disability a lot of the time don't try to do things because they're disabled. I'm not making that clear. Erm, people look at the disability before they look at the person, you know. Erm, erm, the fact that someone's got a really good sense of humour its shocking sometimes because they've got a learning disability and they've got the most wicked sense of humours going, you know. Or from a learning disability, erm, they seem shocked when they are actually asked to do something because possibly, I don't know, maybe they've been …..

J: So other people's expectations …?

R8: Expectations aren't as high as that person can achieve, you know. And its about staffing levels, it's a lot easier to dress somebody than to actually encourage them to do it themselves. But that happens on a ward as well doesn't it?

J: Yes. Yes.

R8 explores issues around informed consent and confidentiality, in relation to learning disability clients. She always treats people with respect and builds a rapport with them and their relatives and suggests that this may be why she has ever been the subject of abuse. R8 reflects on a lecturer on confidentiality in which she challenged the lecturer by not accepting the status quo. She gives the example of discussing sexual issues with learning disability adults and argues that it may not be appropriate for parents to be present. R8 observed that other students were less willing to challenge and seemed keen that the session ended on time. R8 continues to reflect on the rights of learning disability people, as adults, and suggests that over-directive parenting may be a form of abuse. She has observed that many people see the disability, rather than the person and their characteristics and reflects that this may lead to low expectations of learning disability clients.

R8 reflects on issues of informed consent and confidentiality for learning disability clients. She argues that professionals should not assume that information can be shared with relatives and challenges current practice. She also reflects on the behaviour of parents and on the fact that many people see the disability rather than the person, which may lead to low expectations of the individual.

Meaning Unit 14

R8: That was one of the things I found very, you know like we've got the elderly frail and they've got to be fed on the wards, the actual time that takes is, I think, very draining on the staff. Not that they haven't got to do it because they know they've got to do it but it's that actual, it depends on …

J: But to do it with dignity takes time doesn't it?

R8: Yes, yes, that's it. That extra time out for that and what have you, I think as well. They got, erm, I think, have you been to *(names Trust)?* I can't think what its called, they've got this, I think it's quite a good system where everybody was charted, erm, I can't remember what the system was called so its probably, but they chart their needs - if somebody needs bathing they get so much …

J: Like a dependency score?

R8: Yes. So then they do the staffing levels from that which I think is quite good. I don't think it wholly works but it's a lot better than having regimented three staff on in the morning and three staff on in the afternoon. If you need four or five that should be the identified need. I hadn't seen that before and I think that would be quite useful in a learning disability setting.

J: Yes because your clients have got very different dependency levels.

R8 compares her experience with learning disability clients to the care of elderly patients in hospital. She reflects that treating people with dignity is time consuming, e.g. when dressing and observes that using dependency scores may address patients' need for time and may be useful for learning disability settings.

R8 observes that elderly people need to given time, if they are to be treated with dignity. She recognises the value of dependency scores and considers their application to learning disability settings.

Meaning Unit 15

R8: Especially somewhere that's acute like this because clients can change from day to day.

J: So it's very short term?

R8: The ideal is that somebody comes in as a….detained under the Mental Health Act…. here for six months. You've got people that are bed blocking that have been here for two years. So because we've got to develop a service plan for them before they can be discharged.

J: Can it take two years for that to happen?

R8: And more, yes. Because the costings are horrendous. Some places charge £3,000 a month.

J: Really.

R8: Very costly. And it makes you want to go and set up a home!

J: That is a lot isn't it?

R8: Yes a lot of money a year. I think you're talking well over £100,000 a year for some people. Of course if that money goes out of the pot, for that person, there isn't much in the pot for anybody else then is it?

J: Right, so how much does it cost to keep them here?

R8: I think it's quite expensive here but this is health, so social services because we've got the funding thingy.

J: …….service?

R8: Yes so social services aren't in such a hurry to put their pots in.

R8 describes her current placement, which is in an acute learning disability setting, in which patients are detained under the Mental Health Act. She recognises the cost of providing appropriate care for these patients, funding issues and the subsequent effect on the availability of acute provision.

R8 reflects on the issues surrounding funding acute provision and the subsequent effects on learning disability clients who require mental health provision.

Meaning Unit 16

J: So what effect does that have on the clients?

R8: I would imagine, erm, I mean I can talk about difference because I worked part time somewhere in a closed secure unit and they're bed blocked completely. No services. And the psychological effect can be horrendous. I've actually just been involved with one client - they've actually asked me write a letter to her advocate who has got her head in her hands and sobbing. Absolutely sobbing, because she hadn't been through the court system, but she was detained and she didn't feel that she had had any justice and that people had lied to her. Which was probably very true and although she was only in her early forties, she couldn't see getting out of there before she had her pension, and that was her exact words. Because I actually, as her support worker, wrote the letter and made sure it was posted. And I actually phoned the advocate to check she had received the letter because …….. she was just pulling her hair out because people were just pushing her from pillar to post and not getting anywhere with them. I said "there must be some form of redress, you know, these people shouldn't be left like this". I think, you know, although you've got the Mental Health Act there and it's for people, it takes, it locks their rights away. And that's how they felt, not just one person. It was every night. So it's a time when people come and sit and talk to you.

J: Can talk.

R8 describes her experience for a woman who was detained under the Mental Health Act. She reflects on the psychological effect that being detained had on the woman and challenges the way the Mental Health Act affects people's rights. R8 wrote to the woman's advocate in this case.

R8 reflects on the way that the Mental Health Act affects people's rights and she recognises their need for advocacy.

Meaning Unit 17

R8: And for whatever reasons and my argument is, because I asked for this particular place, I wanted to know what the philosophy of the unit was. And the manager couldn't explain to me what the philosophy was. Because I said "you're telling me this is a rehabilitation unit, what do these clients get from being here". I mean I haven't got a problem if they're actually gaining something from being here then you know as far as I'm concerned, you know, everybody is gaining because they're receiving some form of treatment. But they weren't. They had people that had set fires that should be receiving therapy and that service isn't available at the moment. And then you've got other people that, erm, their mental health is quite acute at times but it's all about community care now aren't we, so they should be supported in a community, they shouldn't be in a secure, you know, they haven't done anything major. But you have got people there are under Section, that have been referred from prison as well. So, you know, I mean that's a different scenario isn't it? They, at least they've gone through the justice system and been found not to be able to plead or something. People in there that just, that don't feel like they're listened to at all. It's quite sad.

J: Out of sight, out of mind?

R8: Mmm, yes. That's how I feel.

J: ……I thought we'd moved away from that.

R8: No, no, no. I was actually offered a position there…….. I mean you feel like one of you wants to improve the service but you can't be a one man band either can you?

J: No.

R8: I mean it is, I know this …….. to improve things because it's a learning disability and all the staff are mental health trained.

J: Right.

R8: But they don't take their learning disability into account ……

R8 explores issues surrounding patients in the unit where she is currently placed. She does not think that their needs are being met and challenges whether it is appropriate for many of them. R8 also questions whether mental health staff are appropriately trained to care effectively for learning disability clients.

R8 reflects on the quality of care given to clients on her current placement and challenges it's appropriateness for learning disability clients.

Meaning Unit 18

R8: ……so there are things to address about going in place now, they've got a new hierarchy manager, changing the philosophy. I actually know her personally, that's why I know its happening, not because the staff know it's happening.

J: It will improve?

R8: Yes, yes. But to sit and listen to somebody that's absolutely impressionable how mild their learning disability is because they are quite able to advocate on their own behalf, but they felt they needed somebody else there on their behalf as well.

J: What do you think it is about what you've done in, like past experience whatever, that means that you are, you sound like you're very confident in that situation?

R8: Erm, I think I was very lucky. I mean I felt, when I originally went to work in care I started working in an old people's home and I thought this is a bit … and erm, it's actually somebody that's actually doing her nurse training with me now, erm, she was the assistant manager. She's doing a mental health *(name*) is. And, erm, she was the assistant officer, and it was a social service home and I thought it was brilliant, because it was in a beautiful house. They got up in the morning and their ironing was outside their bedroom door, which I thought was to die for! They'd come home and they'd have a silver service mainly dinner and erm, I just thought it was the bees knees. And she said "no stand back and look at what it hasn't got. Where's their choice in life?" And I think that set me on a good footing. I think once, if you can catch that early on I think, and I couldn't understand. And she said they come home and they have that meal but they don't choose to have it. And the pantry's lost after that. So if they're hungry at half past seven they don't get a choice of going and having a snack. There wasn't at the time, but I think there is now, there's a machine for them to have a drink. And that's in a lot of places they have a drink at eight o'clock, eleven o'clock, dinner, three o'clock. Very much so, yes. And for some people that has to be like that because if they're autistic or something they have to have a very, you know, you understand that. And its needs led. But other people, you know.

J: Institution led?

R8: Yes, yes. And you get staff that are more institutional than…..erm, I mean I do truly believe that it is nothing to do with size, being an. institution. Take that environment away and put it into a group home and that place can be as much an institution if the staff are institutionalised. You know, and it doesn't matter is you've got a frilly quilt cover on your bed, it could still be exactly the same.

J: Yes.

R8 describes her feelings during a previous placement in a nursing home. She was, initially, impressed with the service provided and considered the residents to be lucky. When she was challenged by her mentor, however, she reflected on the residents' lack of decision making and autonomy and the risk of them becoming institutionalised.

R8 reflects on and challenges the lack of autonomy for clients in many institutions.

Meaning Unit 19

R8: Because what I did I actually went from, I worked, erm, as a care assistant in social services and realised that yes this gives me a buzz, I can do this. And deliberately went to work at *(names organisation)* because I knew it was closing down in two years, because I felt that I needed to know where people were coming from. So that I could see what life had changed basically. And I was lucky because I worked with a lot of good staff, and I worked with some bad staff. And I felt that that gave me the, you know, erm, two sides of it, because it wasn't all bad, them bad people went to the community as well, but luckily I don't think they're there any more but it just shows that you know in all settings you get good and bad, and people have got good values and …

J: Do you think a lot of it is down to the individual member of staff?

R8: Yes definitely. Even their experiences. I think everybody has a bad day, don't they?

J: Yes.

R8: You know, I mean somebody once said to me, she said "the trouble with you *(name*) she said your standard of care is up there and mine's there and you won't accept that". I said "I haven't got a problem with that". She actually said it in front of my manager as well which I couldn't believe. And I said "I haven't got a problem, I said, if your care is there, I said, because that's acceptable". I said "what I'm worried about is on your bad days your care is down there because you've got no room to fall below". I said "what you should be trying to achieve is not saying its there but you would like to be high because everybody should actually".

J: We should all be trying to improve?

R8: Yes, yes. And I said its life long. You know, I said you've got to realise what effects you can have on another person's life.

R8 reflects on her experience of working with positive and negative role models. She describes how she challenged a colleague's standard of care and clearly articulates that her own philosophy is to continually strive to improve the standard of care.

R8 reflects on positive and negative role models and articulates her own philosophy which is to continually improve standards of care.

Meaning Unit 20

R8 We all have bad days, I mean this morning I can't put my right hand - I think its the bottle of wine I had last night. What's up with me, I said" it must be me, I can't take wine any more!" But, and I think my son's diagnosed with a mental health problem and I actually think it's me because he wasn't diagnosed until he was seventeen so he's been ill for about ten years, and I've been working in care fifteen. So I think it's actually helped me cope with his illness. Not that it was anything less traumatic because you've got your life expectations. But I, as he became twenty one and said he wanted to live away from home I haven't got a problem with that at all. Where some parents find that, because I think that's normal.

J: It's allowed you to let him go really?

R8: Yes, yes. And also helps you because you can actually set their care packages up, you know with their, you know you can support them so they get a good service. Because they can get left by the wayside and he has on many occasions really. You know, it's only because you start kicking at the doors that…

J: You've got knowledge of the service?

R8: Yes. Some of his experiences have been horrendous. I mean this is before ……ward, it was the old wards he was on and he would be admitted for a drug overdose and four days later I actually realised he was self-medicating. I asked if that had been risk assessed and it hadn't. And they decided then that no, maybe they should be administering the medication. So I would go away and come back an hour later and he was walking back from the pharmacy with all this medication under his arm. They had sent him for his own…..You know.

J: They were going to administer it but he ……?

R8: You know, excuse me Or even things like they'd have the ward round on a Friday morning and it would identified that he was going home on home leave for the weekend and then the drugs, the home drugs have got to be ordered, it took pharmacy time to dispense them. And so they forget to do it. So, four or five people off the ward who were waiting anxiously for the drugs and can go home for the weekend and then told they can't have home leave because their medication isn't available. It happened to *(name*) twice.

J: Are these people with mental health problems?

R8: Exactly. And you're thinking what effect is this having on somebody's mental health. Luckily we only lived at *(name*) at the time so I could actually bring him back to have his meds, but you know, I said I'm doing your job for you. You know. And why should, I mean there were four or five other people that hadn't gone home. I mean the complaints were just back and forth. Because I used to say if I don't complain it'll happen again. You know and erm, it shouldn't be like that.

J: and affect other people who can't stand up for themselves?

R8: Yes. It shouldn't, it just shouldn't happen. But they don't seem to value that.

R8 explores issues around her son's health problems which have had a major impact on her. She reflects that her experience within the programme and her work has enabled her to access services for her son

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R8 is aware that her personal issues have an impact on her programme and work but recognises learning from these.

Meaning Unit 21

J: They didn't take it seriously?

R8: No, they didn't seem to, you know, well it's only weekend leave sort of thing. You know. Maybe not that ….but it wasn't, I don't think it, I mean *(name*) would have been traumatised if he couldn't come home. He was in there quite a while. You know and it's quite important. I mean it has seriously improved because they've got, I don't know if you know *(name*)? Now they've got the acute wards …

J: I don't to be honest

R8: … and then they've got, what they call community units. So they've got one just up the road here, (*name)*. And they've got them like at (name) and they're like I think ten bedded units. So people can go in for respite if they're poorly rather than go onto the acute wards. So it's like a care pathway, so that before they become acute they can go and like in *(name's)* CPA it's identified that if he's poorly that's where he goes to, because he wouldn't, for love nor money come in here. That would make, he would have to really, really, and he wouldn't be compliant. But that's down to his, erm, because it always makes me laugh because there's a client here that's non-compliant with medication. And you'll see him, I don't know if you will today, and it's got adverse effects to long term medication ……because it affects his muscle, he can't hold his head up and I asked them the other day …….reverse psychology he's non-compliant with medication. He said "well why are you asking", I said "well don't you think that it might have actually affected him because he's had these side effects, in the past, on medication and even how much you tell him that the medication is for his good he thinks "fuck you basically". "He's told me that before". Because my son, erm, was prescribed halopeladrol which is an old drug. We convinced him to take it because the psychiatrist wanted him to take it and he had horrendous side effects. Well now, I mean he reads, he actually develops the side effects for everything he has, its horrendous. So, because he reads all the leaflets. And at one point we asked for the leaflets to be taken out. Because if they told you he was

going to have a pimple on the end of his nose it would be there. But you can understand where he's coming from as well. And I never, ever again got involved in …

J: Because you've broke their trust then haven't you?

R8: Yes, definitely. One pill it was.

J: One?

R8: One. Horrendous side effects. He was just having spasms all over the place. So you know but I don't think people actually always look you know.

J: So obviously experience with your son has given you a real insight into mental health issues?

R8: Possibly. Yes, I felt that was why I couldn't do mental health. I think it was too close to me, I would like to do, I think it's a shame that you can't actually pick the modules up within your three years. Because I can't afford to take another twelve months out, because financially its just absolutely crippled me.

R8 describes her experiences with her son and reflects on the attitude of staff and on mental health systems of care. She perceives a lack of understanding of his condition and how it affects him. She reflects that, when he was given medication with major side effects, this seriously undermined his trust in her and in the professionals who had persuaded him to take it. She recognises that it was not appropriate to undertake a mental health programme at the current time.

R8 reflects on her son's experience of mental health services and demonstrates self awareness in terms of her choice of programme.

Meaning Unit 22

R8: But I think in future, I've already identified that maybe, I would like to be seconded this time, on bursary…….. because I think, it's evidenced that people with learning disability are high incidents of suffering from mental health problems, probably because of their life experiences.

J: Like you were saying, here you really need to be dual qualified rather than either one or the other?

R8: Yes, I mean another role that's been developed recently is the health facilitators.

J: Oh - what are they?

R8: There's three just been appointed in different areas of *(names area)* and they've done it is *(names area)* as well. Erm, and they're learning disability nurses, that are facilitating how the clients, and they're working and they're actually being employed by PCTs.

J: Right.

R8: At G level, and facilitating, so they'll be involved at Accident and Emergency and go into GP practices ensuring that clients are recognised first that they've got a learning disability. Because they're not always registered on the GP practice as learning disabled. To ensure that they actually get their check ups because somebody can receive a letter for the smear but if they can't read it they don't attend do they.

J: So it's looking that they get their physical care?

R8: Yes, it's more to do with. So …

J: Would that person support them then when they did go for their appointment?

R8: I don't think they would but they might identify that that need was there.

J: There was a need?

R8: Yes. And then maybe, yes.

J: That sounds like a good role.

R8: Yes sounds very interesting doesn't it? So erm, because I went to a nurse conference in London and they were actually identifying that that was the major role for learning disability nurses……. Because they were looking at where the role was going because it always gets very difficult. So they actually identified that that was the way forward for learning disability nurses - in London anyway.

J: And what do you think about that?

R8 considers her future and would like to complete the mental health programme. She perceives this as beneficial to patients and identifies that new roles are being developed to meet the needs of learning disability clients with mental health problems.

R8 recognises the advantages of a joint mental health/learning disability role to meet client need and hopes to pursue this in the future.

Meaning Unit 23

R8: Yes I think we needed in different settings. I don't think necessarily needed, because I managed group homes and social care for the NHS so it's quite bizarre really. From that point of view I thought it was a waste because there was some of the managers there were nurses. And I thought it was a waste for their nursing qualification. Because it was classed as social care the nurses couldn't use any of their, they couldn't do an enema, they couldn't do an injection.

J: Purely because of the setting they were in?

R8: Yes it's the social care setting. My manager was trained but she couldn't come in and do an enema, we had to get a community nurse in. Yes – bizarre! I mean I felt that the manager's role was about managing staff, supervising staff, training, ensuring that staff received the training, not necessarily you gave them the training and refer to clients to the ….. nurse, who would come in and set the care plan up and I thought it was my job to ensure that care plan was followed. The …. nurse would come in and evaluate it because she was a specialist in that area. If the client needed an enema or injection, we would refer to a community nurse who would come in and ensure that person had that care.

J: A lot of artificial barriers then?

R8: Yes, so sort of, erm, so you've got like community nurses, or you'd have a dietician involved. Because we weren't trained, but so do nurse here, refer to a dietician. And they'd come in and give care plans as far as I'm concerned. It would be like a support worker, you just follow the care plan don't you. But as a manager you're managing the whole list, you know, multi-agency of it sort of thing. I mean we had clients that were diagnosed with schizophrenia and CPAs and a lot of behavioural problems we had and they're all managing in social care setting, I don't think it needed a qualified nurse. I wouldn't like to think that I would use my nurse training to do that. I would rather support people that were doing that. I just felt it was taking you further and further away from the clients. Or it should have taken you further and further away from the clients if I didn't……. Because I don't believe that as a manager, you can't tell people seven days a week bath somebody and know that its been done properly. Because if you do it one day you know if somebody's got any sore areas don't you? Sort of thing. You need to be doing that bit and that's my argument. You need to be keeping you know an eye on things. But I don't know I'm gabbling away aren't I?

J: No, you're going through exactly what I want, just an honest account really

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R8 reflects on the issues surrounding overlap between nursing and social care. In her past experience, as the manager of a social care home, R8 challenges the distinctions in tasks.

R8 reflects on her role as social care home manager and challenges the boundaries between health and social care.

Meaning Unit 24

J: Is there anything else that particularly sticks in your mind, any particular experiences that…….?

R8: The one experience is that I got from general that, because you got a fair few patients that would be admitted to the ward because they'd got a fracture and they'd be identified it's because they've got cancer because it goes into the bones doesn't it?

J: Pathological fracture, yes.

R8: And I was horrified at how long it then took to involve, because they were under consultant for orthopaedic, how hard it was to get the care for them for the cancer sort of thing. And erm, erm, pain relief even. I sort of, I thought, I mean the patients, unless they actually knew the system, wouldn't be aware that it was taking longer than it should. I found that very frustrating. I was involved with a lady who had been admitted, very poorly, had fractured her hip. And she was red carded because she was that poorly. So they weren't going to resuscitate and pulled through. And, as she became well she was very chirpy, very independent, ninety two. And she had got a lovely character, lived at home on her own and just as she was being discharged they discovered a lump in her breast. So she did get an appointment straight away and I escorted her down and that was an horrendous experience. Erm, the communication with the patient was zero. Erm, we went first to the breast clinic, they sent us along for a mammogram. She went back, they'd looked at it didn't tell her the results and then sent her down to have erm, I'm not going to tell you the terminology, but where they withdrew …

J: Fine needle aspiration.

R8: … and this, he was a doctor, she got the lump in her right breast and he went to do that one and she was compliant. And then he said "right, and the other one. And she said I don't need it in the other one, I've only got the lump in this one. And he said no you've got lumps in both breasts." And I said "I don't think Mrs has been informed of this doctor". I was, I could have hit him round the head I could. I mean, you know, he probably, just get blasé I suppose. And he said "oh right, well

you've got lumps in both breasts". And she just turned to me and she said "that's enough, I've lived long enough". And eventually she went "no I've had enough" and he went to do it again and I said "I think she's withdrawn her consent doctor". And I was welling up. And so I took her out and we went along and they told they'd got to do another where they actually took erm…

J: Took tissue?

R8: Yes. And, which I thought was another horrendous experience. They injected her with anaesthetic and I said to the nurse afterwards, because they did that and then did the procedure straight away. And I said "does it not take a while, because I didn't think it should have hurt her and it did." And she said "oh it does take a little while". Because I was questioning his practice. And they didn't actually realise I was a student I think because I was mature.

J: You weren't in uniform?

R8: I was in uniform but I think,

J: Oh right.

R8: … so I was actually (turn tape over) deeply involved, their to explain to her and the doctor prescribed her hormones because there wasn't going to be any more treatment. And she was deaf but she seemed to be able to pick up, whether it was because she knew me and she had got confidence, so I had to relay all the time to her what was being said to her. And the doctor was Asian, so I don't think she could understand him. And, erm, he said we're going to do this treatment. And I said "before I relay that doctor can you tell me, I said is she's having this hormone treatment because of her age or because that is the best, because it's the best treatment for the form of cancer she's got". I said "in case she asks that question to me next" and he said "oh it's the best treatment" and I said because I said "she might want to know why she's not having an operation because breast cancer presumably you were going to do some operation". So I said "they've given you some tablets and explained all that to her" She said to me, she said" I've had enough now, I've lived long enough". And I thought what a shame, she's now going to have to go into a nursing home and she lived independently. But the communication there I thought was absolutely zero. You know, somebody should have sat down from the mammogram and said "they've identified……I think there's more …." Nobody bothered to take that step. It's probably bad communication the

fact that she was deaf. But she could hear if you took time out to talk to her.

J: What would you say you'd taken from that then?

R8: About how important communication is I think and about consent. Because people weren't listening to her. And all along it should be built into the care package shouldn't it, and consent in all the way through.

J: Yes.

R8: Because that's one of my son's horrors, because he has in the past been detained under the Mental Health Act, given electric, ECT without his consent can't they.

J: Take his control away?

R8: Yes and she was, she was very, you know, she knew what she was saying, "no I've had enough, I've lived long enough". I mean that's clearer than anything isn't it. But I said to her "are you sure, would you like to think about this?" "No I've lived long enough. Long enough now. No." I went ……. I think that's sad as well because, like in learning disability service you're always, because I think the service is so insular you always get to know what's happened to clients.

R8 relates an experience on a general ward in which a patient was admitted with cancer and pathological fractures. She found it very frustrating that the patient had to wait for care and the way that the patient's wishes were disregarded. Communication with the patient was very poor and she was not informed that the lumps in both breasts were malignant. R8 recognised that the doctor was not listening to the patient's views and acted as her advocate.

R8 reflects on a distressing experience in which a doctor's attitude resulted in the patient withdrawing consent to treatment. R8 acted as the patient's advocate with the doctor.

Meaning Unit 25

R8: Whereas when they're discharged from hospital you don't know do you?

J: You don't have the follow up.

R8: No, I find that very frustrating.

J: Where you've got the continuing care.

R8: Yes, yes. And you find out what's happened to somebody fifteen years down the road really. You know, unless they've gone out of area which could happen with anybody I suppose.

J: Do you find that is useful finding out what's happened later on?

R8: Yes, personally I think, yes. I mean hopefully it's a good outcome (laughs).
Running down a railway track somewhere. Yes I think from your point of view because you can gauge then sometimes towards that little bit that you did well. You know I think it's an inspiration for you sometimes.

R8 explains that she finds it frustrating not to know the outcome for patients once they have been discharged.

R8 explains that she finds it frustrating not to know the outcome for patients once they have been discharged.

Meaning Unit 26

J: Would it ever make you sort of think oh well next time I'd do it differently?

R8: Oh definitely. Yes. And I think because like if you're in a violent incident, erm, you're supposed to have debriefing and my argument always was in the past experiences you're getting debriefed you're going to have make changes because debriefing is about re-evaluating how you react…. I've known many a time I won't do that again, that wasn't a good call! You know. It could be something like they're saying sausages because the person doesn't like sausages. I mean a biggy for learning disability is mentioning the word diet. They've been on that many horrendous diets and again you're saying healthy eating now. That's - I'm not going to eat a lettuce leaf! You know don't put me on a cabbage soup diet. Horrendous experiences of that. Erm, I'll never say that word again. But yes, I think I think debriefings very, very valuable because you need to reflect don't you.

R8 agrees that she learns from experience and debriefing and that this leads to her making behaviour changes

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R8 values debriefing and reflection.

Meaning Unit 27

R8: I mean I find that difficult in assignments. Erm and I found that assignment, the value of assignments - I know why you do them, but you know where you've got your evidence from sort of thing but actually taking the time out to actually do, I start mine on a Sunday night when they've got to be in for Monday – bottle of wine job and then take all the swear words out the next day! So and then get angry with myself because you know when you then start getting interested in something – I could have done really, put more into this. Because I've always had to work part time as well with my training. It's a lot more difficult especially when you're doing shifts. Because I've been doing what, twenty, thirty hours a week on the side …

J: On top of your training?

R8: … yes. I'll end up selling my house and then regretting it.

J: Life will get easier when you are qualified

R8: Thirty seven and a half hours sounds just - I've never done thirty seven and a half hours I don't think.

J: You probably never will.

R8: I'm going to try because I think if you get used to the money, you do don't you.

J: Just staying for half an hour afterwards to do …

R8: Oh well, I think everybody does that don't they? Night time management's not the best, but I thoroughly enjoyed the experience of it and …

R8 explains that she works extra hours on top of her programme and that she finds it very difficult to find the time to complete assignments.

R8 finds that workload impinges on her ability to complete assignments.

Meaning Unit 28

J: It certainly sounds like you've learnt a lot.

R8: Yes and I think, you know some people moan about the placements I think you only get out of the placement what you put in.

J: Yes

R8: Definitely. I would say well I'm seeing this, that and I've made appointments way out, erm, something that I've found here because they have *(other university) students*. Now I would normally make appointments to go out into the service and work with community nurses and that's a no no.

J: Oh really?

R8: Yes, very, whether they're just not used to it.

J: That's interesting.

R8: And I'm……young leader - you might know her because she's from *(names university*). I must admit we don't see eye to eye, for whatever reason. It's one of them – want to be in my gang? And I don't belong to a gang. Know what I mean. And erm, she sort of said well you'll be doing nights. I said "well actually *(name)* I won't. It's my management module. If you can tell me that I'm going to experience management issues working nights ……. I said I'm, I haven't got a problem doing nights you know, you get the hours in easy don't you, but I need experience please. And I've already spoken to my tutor and *(name)* is aware, about working nights. I'm not going to do nights to make your numbers up". Some of the younger …

R8: … but that's because ……. expecting to do nights to get the numbers in you see.

J: But it was a different experience for you?

R8: Yes. It was my management module so I said I just need to, I work nights anyway. I work nights on my part time job two nights a week. So it's not that I actually because nights would fit in beautifully, it's just the experiences and some community nurse came in and they used to laugh at me because they asked me to do observations on clients. Can I do observations ……. well they don't do Saturdays and Sundays do they? It's fitting with my life as well. And I said well you know that fits into the day centre all week, how can I help ….. They thought it was brilliant because they were getting their observations done …

J: And you were..

R8: Yes, yes, because their clients sort of thing. But I haven't got a problem with that at all. I …..I did actually do one night… a child….you know parental care, parental skills really to the mum. I should have had them years ago really – No!
Laughs.

R8 describes some difficulties in obtaining relevant experience because she was expected to work night duty which she has experienced in previous jobs.

R8 felt that she was being used as a member of staff and this impinged on learning opportunities.

J: Well shall we call it a halt there. That was really, really useful. Exactly what I wanted. Anything you've said that you want to withdraw.

R8: No.

J: Anything else you have a burning …

R8: No, not really.

J: No?

R8: No.

J: Okay that was really good thank you.

Appendix 7

Situated Structure of Learning: Interview Eight

Situated Structure of Learning: Interview 8

R8 compares her experience on general wards to that in learning disability and mental health areas and reflects that she would find the lack of time to spend with patients, in general nursing, frustrating. R8 explores her role as a student and reflects on her appreciation when qualified staff spent time with her. She reflects that, in her experience and that of fellow students, supernumerary status is not always adhered to. R8 explained that her status, as a mature student, enabled her to explain her role to mentors and to integrate into the team. She compares this with the experience of younger students whose understanding of the term 'supernumerary' sometimes caused problems on placements. R8 displays a mature attitude towards her role as a student and her place in the team and compares this to the attitude of younger students.

R8 reflects on her learning from positive feedback from patients in relation to clinical skills and recognises the importance of telling patients she was a student when gaining consent. R8 values feedback from patients to help her learn and gain confidence in clinical skills and recognises the need to obtain consent. R8 explains that, as a student, she has time to talk to patients, whereas this is compromised for qualified staff, on a busy ward. She explains that her programme emphasises communication. R8 reflects on the difficulties of effective communication within a busy ward environment.

R8 reflects on her experience of caring for elderly patients on an orthopaedic ward. She describes the system of transferring patients to nursing homes, to prevent 'bed blocking'. She recognises that this is a traumatic experience for many patients and is surprised and frustrated that nurses do not act as their advocates. She compares this to learning disability nursing where the advocacy role is very strong. R8 recognises the needs of elderly patients and is disappointed in the nurses' lack of advocacy which she compares to her own experience within learning disability settings. R8 explains that urine infections can cause confusion in elderly patients and that this can influence their recovery. She observed that his affected a large number of patients on one ward and reflects that the infections could have been identified at an earlier stage. She uses her previous experience, in social care settings to reflect on this experience. R8 reflects on the care of patients in hospital with urine infections and applies knowledge from previous experience to suggest improvements to care. She compares her own knowledge, gained from experience, to that of younger students and reflects that her experience has helped her to learn more effectively during the programme. R8 reflects on the role of experience in her learning.

R8 explains that, due to her previous experience, she was given more responsibility than other students during her placements. She identifies the importance of acute learning disability placements as learning opportunities and reflects that students who do not get an acute placement (due to placement shortages) may have a distorted view of the role of learning disability nurses, which can lead to lack of respect. R8 reflects that if students are not exposed to acute placements, they may not have an accurate perception of the role of learning disability nurses.

R8 describes her experience on a rural placement over the Christmas period. She recognised the anxiety that this causes many patients and the potential impact of there being reduced services at this time. She reflects on the care provided by a positive role model, who made herself available at this time. R8 reflects on the

behaviour of a positive role model, who recognised the potential effects of Christmas on patients and responded appropriately.

R8 explains that she has experienced good services for clients and so had encountered very few complaints. She then reflects on a difficult situation within a general ward when a patient was very problematic. He complained regularly and refused to give up a single room to accommodate a terminally ill patient. R8 describes how the PALs service, social workers, security and the police all became involved when he insisted on driving but was not safe to do so. Although she recognises the need to treat patients in a non-judgemental way, R8 expresses her annoyance at the way a particular patient manipulated the system.

R8 explores issues around informed consent and confidentiality, in relation to learning disability clients. She always treats people with respect and builds a rapport with them and their relatives and suggests that this may be why she has ever been the subject of abuse. R8 reflects on a lecturer on confidentiality in which she challenged the lecturer by not accepting the status quo. She gives the example of discussing sexual issues with learning disability adults and argues that it may not be appropriate for parents to be present. R8 observed that other students were less willing to challenge and seemed keen that the session ended on time. R8 continues to reflect on the rights of learning disability people, as adults, and suggests that over-directive parenting may be a form of abuse. She has observed that many people see the disability, rather than the person and their characteristics and reflects that this may lead to low expectations of learning disability clients. R8 reflects on issues of informed consent and confidentiality for learning disability clients. She argues that professionals should not assume that information can be shared with relatives and challenges current practice. She also reflects on the behaviour of parents and on the fact that many people see the disability rather than the person, which may lead to low expectations of the individual.

R8 compares her experience with learning disability clients to the care of elderly patients in hospital. She reflects that treating people with dignity is time consuming, e.g. when dressing and observes that using dependency scores may address patients' need for time and may be useful for learning disability settings.R8 observes that elderly people need to given time, if they are to be treated with dignity. She recognises the value of dependency scores and considers their application to learning disability settings.

R8 describes her current placement, which is in an acute learning disability setting, in which patients are detained under the Mental Health Act. She recognises the cost of providing appropriate care for these patients, funding issues and the subsequent effect on the availability of acute provision. R8 reflects on the issues surrounding funding acute provision and the subsequent effects on learning disability clients who require mental health provision.